Maternal and Child Health Services
Title V Block Grant

State Narrative for Illinois

Application for 2011
Annual Report for 2009

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Illinois Department of Human Services' (IDHS) assurances and certifications of compliance with federal statutes and regulations that pertain to the Maternal and Child Health Services Block Grant are on file at the IDHS Division of Community Health and Prevention's (DCHP) headquarters in Springfield. Copies may be obtained by writing or calling the office:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Illinois' MCH Services Block Grant application was made available for public review/ comment via posting on the internet at www.dhs.state.il.us between June 7 and June 30, 2010 . A legal notice inviting public comment was published in the Arlington Heights Daily Herald, which has been designated as the official newspaper for publication of the State's legal notices.

The application was made available to the Expert Panel for the needs assessment, and to all of the participants in the professional and consumer forums conducted for the needs assessment, IDHS' Maternal and Child Health Advisory Board, the Division of Specialized Care for Children (DSCC) Family Advisory Council (FAC), Voices for Illinois Children, Family Voices, Family to Family (F2F) Health Information Center, the Illinois Maternal and Child Health Coalition (IMCHC), the Kids Public Education and Policy Project, and the Maternal and Child Health Training Program at the University of Illinois at Chicago (UIC) School of Public Health.

The public posting of the block grant application yielded comments from three important Illinois maternal and child health advocates: The Arc of Illinois, Illinois March of Dimes and Illinois Planned Parenthood. In general, the comments were positive and instructive. The Arc of Illinois called for the collection of data on children with special health care needs (CSHCN) who are eligible for services from the DSCC. In its comments, the Arc recommended several approaches

to gathering this data especially that reported through Individual Family Services Plans (IFSP) for Early Intervention. Several of the recommended approaches are in place. For instance, using its Cornerstone information system, the DCHP can identify maternal and child health clients who have an Individualized Family Service Plan (IFSP). The area that needs further exploration is the optimal use of the Prioritization of Urgency of Need for Services (PUNS) database that is operated and maintained by the DHS Division of Developmental Disabilities. In FFY2011, the Title V program will work to maximize the use of PUNS to identify unmet need in Illinois. Illinois Planned Parenthood offered important insights to the significance of family planning services to the overall health of women and children. In particular, Planned Parenthood is convinced that family planning services will have a strong role in the Title V program's ability to address many of its priorities, specifically: #2 - Integrate medical and community-based services for MCH populations and improve linkages of clients to the services; #4 - Expand availability, access to, quality, and utilization of medical homes for all children and adolescents, including CSHCN; #5 - Expand availability, access to, quality, and utilization of medical homes for all women; and #6 - Promote healthy pregnancies and reduce adverse pregnancy outcomes for mothers and infants. Finally, the Illinois March of Dimes agreed with the Title V agency's life course approach/ecological model to address the needs of mothers and children. It also strongly recommended that the Title V agency foster open communication and robust collaboration among all MCH providers. The March of Dimes also suggested that the Title V agency examine the factors associated with infant mortality in communities outside of the greater Chicago area, particularly those in southern Illinois.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The 2011 Illinois Title V needs assessment began in January 2009 with the development of a workgroup from the Illinois Department of Human Services, the University of Illinois at Chicago Division of Specialized Care for Children and the Maternal and Child Health Training Program at the University of Illinois at Chicago School of Public Health to plan the process. Two main theories guided the needs assessment process: the life course theory and the ecological model. These models complement each other by providing insight into the pathways through which health is influenced and recognition of the complex array of systems that mediate those pathways.

A major goal of the Illinois Title V needs assessment was to involve a wide variety of stakeholders in the data gathering, data interpretation, prioritization, and priority and performance measure development processes. Through this needs assessment, the Illinois Title V program sought to cast a wide net in seeking input from partners and to conduct a needs assessment that promoted collaboration and systems-thinking. An Expert Panel of eleven professionals external to the Title V program was convened to provide input into the needs assessment process, review data, and select priorities. As well, public input was sought through a series of community forums around Illinois in fall 2009; a total of 205 providers and 90 consumers participated. Information obtained from the community forums pointed towards a need for Illinois to improve service integration. Improving Illinois' data infrastructure was consistently suggested as a way to prevent service duplication, track clients and ultimately support more efficient service delivery.

A variety of state and national data sources were used to gather quantitative information on the health of Illinois women, infants, children, adolescents, and children with special healthcare needs. These data were combined into a databook for review, interpretation, and synthesis by Expert Panel and Needs Assessment Workgroup members. In general, the data indicated the health of mothers and children in Illinois is marked by either a lack of or slow improvement in morbidity and mortality despite an array of health services. The need may be to modify and refine existing interventions, and to advocate for more innovative strategies. Disparities in health status are evident across most areas of maternal and child health. In particular, the black-white gap is persistent on many indicators, and disparities by income and insurance status are also important. As well, the complex needs of CSHCN are not currently being completely met.

Based on the information in the databook and the qualitative data from the community forums, a list of 52 potential needs was proposed to the Expert Panel in a ranking exercise. The final ranked list of items was discussed in detail by the Expert Panel and Needs Assessment Workgroup and led to the development of 16 potential state priorities, from which the final list of ten priorities was developed. Because of the new framework used in this needs assessment, all of the Illinois MCH priorities have changed since the last needs assessment. In addition, nearly all Illinois state performance measures (SPM) were changed from the last needs assessment as Illinois selected one SPM to correspond to each of the ten new priorities.

Illinois Title V recognizes that the needs assessment process is cyclical and ongoing and will strive to update this document annually. Workgroups will be convened later in 2010 to address each priority to further review data and develop a strategic plan for Title V over the next five years.

III. State Overview

A. Overview

POPULATION - Illinois ranks fifth in the nation in population, with 12.9 million people, including 3.2 million children under the age of 18, according to the U.S. Census Bureau's population estimates as of July 1, 2009. In the year 2009, there were approximately 2.7 million women in Illinois who were of childbearing age (15 to 44 years). In recent years, Illinois has averaged about 180,600 live births annually. An average of 45,300 pregnancies are aborted each year.

According to the 2005-2006 (most current) National Survey of Children with Special Health Care Needs (CSHCN), there are about 451,776 CSHCN in Illinois, or 13.9 percent of children under 18 years of age. In comparison, the survey identified 10.2 million CSHCN nationally, or 13.9 percent of children under 18 years of age. The survey identified 323,673 Illinois households with a CSHCN, or 19.1 percent of the state's households. 20.9 percent of all households in the nation had a CSHCN. DSCC serves approximately 24,000 CSHCN with their current resources.

Sixty-six percent of the state's population resides in Chicago and the six "collar" counties that surround it in the northeast corner of the state; two of those counties (Cook and DuPage) account for half of the state's population. Excluding Chicago, 26 cities of 50,000 or more in population account for over 2.1 million persons, or about 17 percent of the state's population. Using 2009 population estimates, there were 19 counties outside the collar counties whose populations exceeded 100,000. Other than these population centers, Illinois is characterized by rural areas. Using the U.S. Department of Agriculture (USDA) Rural-Urban Continuum classification scheme and 2007 population data, nine of the 102 counties are considered "completely rural," with less than 2,500 urban population regardless of proximity to a metropolitan area. Another 57 counties are considered "urban," with an urban population of 2,500 to 19,999 regardless of proximity to a metropolitan area. About two thirds of Illinois' population (Chicago and the collar counties) is concentrated on less than 10 percent of its land, while the majority of the state is characterized by small towns and farming areas.

In 2008, the U.S. Census Bureau estimated that 79.1 percent of the state's population was Caucasian, 14.9 percent was African American, 4.3 percent was Asian, Native Hawaiian or Other Pacific Islander, 0.4 percent was Native American, and 1.2 percent was multiracial; 15.2 percent of the state's population was of Hispanic origin. Chicago is home to more than half of the state's African Americans and 49 percent of the state's Hispanic Americans.

The size of Illinois' rural area is a significant geographic barrier to health care. The Illinois Department of Public Health (IDPH) Center for Rural Health reports that there are 83 rural counties and 19 urban counties in Illinois. The Center further reports designation of Health Professional Shortage Areas (HPSA's) by county, township, and Census tract. Through calendar year 2008, all but four counties (96 percent) of Illinois have some category of HPSA designation: 45 are geographic; 43 are low-income population; and 10 are sub-county level. This problem of provider distribution in rural areas creates barriers to care arising from problems with transportation, child care, hours of service, and related concerns. Families in some rural areas may have to travel three hours to access specialists' services.

SUMMARY OF HEALTH STATUS - The most important health care needs of the state's population can be considered by population group. The most recently available data are presented.

Access to Prenatal Care - Early and continuous access to prenatal care remains a challenge. Overall, more than 80 percent of the pregnant women in Illinois initiate prenatal care in the first trimester and more than 80 percent receive adequate care (using the Kotelchuck Index of adequate prenatal care) throughout pregnancy. These rates are lower among women who participate in Medicaid. Approximately 10 percent of expectant women continue to smoke in the

third trimester of pregnancy. (Refer to National Performance Measures 15 and 18 on Form 11, Health Systems Capacity Indicator 4 on Form 17 and Health Systems Capacity Indicator 5d on Form 18.)

Newborn Screening - Virtually every newborn in Illinois is screened for a panel of heritable conditions and for congenital hearing loss. The systems to ensure that these infants receive a diagnostic evaluation and on-going care are well established. (Refer to Form 6 and to National Performance Measures 1 and 10 on Form 11.)

Perinatal Health Care - More than 82 percent of very-low birth weight infants are born in hospitals equipped to care for high-risk deliveries and neonates. Illinois' regionalized perinatal care system is well established. (Refer to National Performance Measure 17 on Form 11.)

Infant Mortality - Illinois' infant mortality rate is steadily declining. However, significant racial disparities in infant mortality persist: the rate for African Americans is more than twice that of Caucasians. In 2007, ratio of Caucasian to African American infant deaths was 1:2.5 which differs slightly from that reported five years earlier (1:2.6, 2003). While Chicago's infant mortality figures suggest continued improvement, those for downstate (all geographic areas outside the city of Chicago) reported an increase, especially compared to past years. This is due in part to the gentrification of certain areas of Chicago and the resultant shift in demographics. The mortality rate among Medicaid-insured infants is also higher than the rate among other infants. An average of 180,600 live births and 1,200 infant deaths occur each year. (Refer to National Outcome Measures 1 and 2 on Form 12 and Health Systems Capacity Indicator 5b on Form 18.)

Childhood Health - Approximately 1.5 million children in Illinois are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). Approximately two-thirds of eligible children receive at least one health service during the year. The proportion of infants who are eligible for Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and who receive at least one recommended health screening is approximately 85 percent; the proportion of SCHIP-eligible infants who receive at least one health screening is higher, but the number of participating infants is much smaller. Less than six percent of children (including adolescents) in Illinois are uninsured. (Refer to National Performance Measure 13 on Form 11 and Health Systems Capacity Measures 2 and 3 on Form 17.)

Breastfeeding - The proportion of breast-fed infants in Illinois' WIC program remains above 66 percent. The proportion who are still breast-fed at six months of age has increased significantly over the last two decades but has declined slightly in recent years. (Refer to National Performance Measure 11 on Form 11.)

Childhood Immunization - According to CDC's National Immunization Survey data, the proportion of children ages 19 - 35 months in the U.S. who are fully immunized against measles, mumps, rubella, diphtheria, pertussis, tetanus, polio, haemophilus influenzae B and Hepatitis B reached 75 percent for those children between the third quarter of 2008 through 2nd quarter 2009. For the Illinois project area, excluding the city of Chicago, the same series coverage measures 74 percent. It is believed that a national Hib vaccine shortage between December 2007 and July 2009 affected overall series coverage and may have disrupted follow-up at the local provider level necessary to keep children on schedule. (Refer to National Performance Measure 7 on Form 11.)

Childhood Obesity - Approximately 30 percent of the children between two and five years of age who are enrolled in Illinois' Special Supplemental Nutrition Program for Women, Infants and Children (WIC) have a Body Mass Index at or above the 85th percentile. (Refer to National Performance Measure 14 on Form 11.)

Oral Health - Access to oral health care for Medicaid-eligible or uninsured children in Illinois remains a significant challenge. Slightly more than one-fourth of children in third grade have a sealant on at least one permanent molar tooth. The proportion of children between six and nine

years of age who are eligible for Medicaid has been steadily increasing and now exceeds 50 percent. (Refer to National Performance Measure 9 on Form 11 and Health Systems Capacity Indicator 7B on Form 17.)

Teenage Pregnancy - Overall, the number of teen births and the proportion of infants born to teenage mothers are steadily declining; the birth rate among girls who are between 15 and 17 years of age remains steady. (Please refer to National Performance Measure 8 on Form 11.)

Childhood Injury and Death - The mortality rate among children under 14 years of age due to unintentional injuries decreased, while deaths due to motor vehicle crashes increased slightly The rate of non-fatal injuries requiring hospital admission has declined steadily; the rate of hospital admission for motor vehicle crashes comprises approximately five percent of this rate. (Refer to National Performance Measure 10 on Form 11 and to Health Status Indicators 3A, 3B, 4A and 4B on Form 20.)

The rate of suicide among Illinois' adolescents remains low; approximately 60 adolescents take their own lives each year. (Refer to National Performance Measure 16 on Form 11.)

Reproductive Health - According to the Alan Guttmacher Institute, Illinois has about 708,670 (2008) women of reproductive age in need of subsidized family planning services. Illinois' Family Planning program had enough resources to serve approximately 17% (2009) of these women.

Children with Special Health Care Needs - The 2005/2006 National CSHCN survey found that 60.3 percent of families with CSHCN indicated that they are partners in decision making at all levels. For Children and Youth with Special Health Care Needs (CYSHCN) enrolled in DSCC, assessment and planning incorporates the family's priorities and needs. System efforts such as Medical Home, Transition, Newborn Hearing Screening, Early Intervention and the Integrated Systems Grant Advisory Committee integrate family participation. (Refer to National Performance Measure 2.)

The 2005/2006 National CSHCN Survey found that 45 percent of CSHCN received care in a medical home. In the 2009 DSCC Family Survey, 93 percent of respondents felt they had a partnership with their primary care provider. Families were also asked how strongly they agree/disagree with six statements that indicate elements of a medical home. Families were least likely to agree with the statement that their personal doctor or nurse helps arrange for other health care services needed for their child and most likely to agree that their personal doctor or nurse treats their child with compassion and understanding.

For CYSHCN enrolled in DSCC, care coordination teams work with the family and primary care provider to promote a medical home. DSCC staff facilitate Quality Improvement Teams through the Building Community Based Medical Homes for Children and provide consultation to the Autism Program (TAP) HRSA grant. (Refer to National Performance Measure 3.)

The 2005/2006 National CSHCN survey found that 59.3 percent of Illinois families with CSHCN had adequate private and/or public insurance to pay for the services they need. Approximately five percent of children enrolled in DSCC have no third party benefits. In FY 2009, 45 percent of DSCC financially eligible families received DSCC financial assistance for eligible services. The National Survey also found that 23.4 percent of families with CSHCN pay more than $1,000 out of pocket. The DSCC Family Survey found that 17 percent of families enrolled in DSCC paid $1,000 or more out of pocket. In the 2009 DSCC Family Survey, less than one in five families reported that cost was a major factor in deciding whether their child received medical care. About one in 20 families reported that in the last 12 months, their child was denied care because the family could not pay. About 15 percent of families surveyed reported in the last 12 months, that the family went without necessities because of the cost of medical care. (Refer to National Performance Measure 4.)

The 2005/2006 CSHCN Survey found that 89.8 percent of Illinois families of CYSHCN reported that community-based services systems were organized so that they can easily use them. In the 2009 DSCC Family Survey 56 percent of families with CYSCHN reported one or more barriers to receiving services. The top five barriers reported were: needed service too far from home; All Kids/Medicaid not accepted; care not covered by insurance; delays in getting appointments; and waiting time in doctor's offices too long. CYSHCN enrolled in DSCC, including over 600 children enrolled in the Home and Community Based Services (HCBS) Medicaid waiver, receive care coordination, including comprehensive assessment and service plan development based on the family's priorities and needs. The DSCC 2009 Family Survey found the five most common reasons DSCC families requested care coordination assistance often or sometimes was: to meet with schools to help teachers plan; to help the child get special school services; to learn the child's rights for school; for help talking to medical providers; and help in understanding the medical treatment plan. Coordination with state programs such as the Adverse Pregnancy Outcome Reporting System (APORS), Supplemental Security Income (SSI), and Early Intervention (EI) promote referral and resource identification for CYSHCN. Through the U.S. Health Resources and Services Administration (HRSA) integrated systems grant and collaboration with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) and other stakeholders, systems development is occurring for medical home, transition and other components. (Refer to National Performance Measure 5.)

The 2005/2006 National CSHCN Survey found that 44.2 percent of Illinois youth and their families received the services necessary to make the transition to all aspects of adult life. The 2009 DSCC Family Survey found that 87 percent of youth served by DSCC either have a transition plan or are developing a plan compared to 45 percent reporting having or developing a plan in 2005. The school system most commonly (68 percent) assists with developing the plan. Almost one-third reported that the DSCC Care Coordinator assisted in plan development. Forty-two percent of families reported that the transition plan met their youth's needs extremely or very well. DSCC also conducted a survey of DSCC enrolled youth/young adults in July 2007 to evaluate services being received and transition issues. More than half of the respondents had a written transition plan. There was a slight increase in the percentage of respondents attaining skills related to medication knowledge and knowing the name of their insurance coverage. Over half the respondents order their own medical supplies; less than half are completing medical history forms at the doctor's office and signing medical consents forms. Fifty-six percent of respondents rated DSCC transition assistance as "most helpful" or "very helpful." DSCC participates on Interagency Coordinating Council for Transition with other state agencies. (Refer to National Performance Measure 6.)

HEALTH CARE FINANCING -- Illinois offers a variety of medical care coverage programs, as described below.

All Kids - Children in Illinois may receive publicly subsidized health insurance through the All Kids program. Coverage is available to all uninsured children in Illinois regardless of income or immigration status. All Kids has several components, as follows:

(1) Moms and Babies - Coverage through Title XIX (Medicaid) for pregnant women and their infants up to one year of age, with family incomes up to 200 percent of the federal poverty level (FPL).

(2) All Kids Assist - Coverage through Title XIX, Title XXI (CHIP), and state subsidized health insurance for children through age 18, with family incomes at or below 133 percent of the FPL.

(3) All Kids Share - Coverage through Title XXI and state subsidized health insurance for children through age 18, with family income above 133 percent and at or below 150 percent of the FPL. Co-payments are assessed for prescriptions and medical visits, except for well-child visits and immunizations.

(4) All Kids Premium Level 1- Coverage through Title XXI and state subsidized health insurance for children through age 18, with family income above 150 percent and at or below 200 percent of the FPL. Monthly premiums are assessed based on family size and co-payments are required for prescriptions, physician office visits and non-emergency use of the Emergency Department. There are no co-payments for well child visits or immunizations, and there is an annual limit on the amount families are required to pay. There are seven additional tiers (levels) of premium and co-payment amounts and annual out-of-pocket payment limits that are based on family size and income.

(5) All Kids Rebate -- Offers state-subsidized rebate payments to families with private health insurance or employer sponsored group health insurance coverage for their children. The health insurance must cover at least physicians' services and hospitalization. Children through age 18 with family income above 133 percent and at or below 200 percent of the FPL are eligible.

(6) All Kids Expansion -- Offers state-subsidized rebate payments for insured children under age 19 regardless of family income or immigration status.

Information about All Kids is available at www.allkids.com. As a Health Services Initiative under Title XXI, Illinois provides presumptive eligibility for children requesting medical benefits under both Title XIX and Title XXI.

FamilyCare - This program provides coverage for parents and relatives who care for children under age 19. FamilyCare has four components, as follows:

(1) FamilyCare Assist - Coverage for parents with incomes at or below 133 percent of the FPL. Co-payments for medical visits and brand-name pharmaceuticals are required. There is no charge for generic prescriptions.

(2) FamilyCare Share - Coverage for some parents with income above 133 percent and less than or equal to 150 percent of the FPL. Co-payments are required for medical visits and brand name pharmaceuticals. There is an annual limit on family co-payments.

(3) FamilyCare Premium Level 1 - Coverage for some parents with incomes above 150 percent and less than or equal to 185 percent of the FPL. Monthly premiums are assessed and based on family size. Co-payments are required for medical visits and name-brand pharmaceuticals. There is an annual limit on family co-payments.

(4) FamilyCare Rebate - Health insurance premium subsidy to families with private or employer-sponsored group health insurance coverage. The private insurance plan must at least cover physicians' services and hospitalization. Adults in families with incomes above 133 percent and less than or equal to 200 percent of the FPL are eligible.

Information about Family Care is provided at www.familycareillinois.com

Illinois Healthy Women (IHW) - Provides coverage for family planning services. The program operates under a Section 1115 Medicaid waiver to demonstrate the program's impact on the rate of unintended pregnancy and associated savings to the Medicaid program. The program covers women who are ages 19 through 44, who are U.S. citizens and Illinois residents with family incomes at or below 200 percent of poverty. Information about the IHW program is provided at www.illinoishealthywomen.com.

Illinois Health Connect - Illinois Health Connect is the statewide Primary Care Case Management (PCCM) program for most persons covered by All Kids or FamilyCare. Participants are assigned to a medical home through a Primary Care Provider (PCP), which ensures that clients have access to quality care from a provider who understands their individual health care needs. A client's PCP serves as his/her medical home by providing, coordinating and managing the client's

primary and preventive services, including well child visits, immunizations, screening, and follow-up care as needed. Having a PCP also helps those with chronic conditions like asthma, heart disease or diabetes to get the treatment and ongoing care they need to minimize the need for hospital care. The PCP will also make referrals to specialists for additional care or tests as needed. There are currently over 1.9 million Illinois Health Connect clients with a PCP in a medical home. Information about the program is provided at www.illinoishealthconnect.com.

Disease Management - Your Healthcare Plus is a disease management program implemented in 2006. Your Healthcare Plus supports medical providers with the management of patients with complex chronic illnesses. The Illinois Department of Healthcare and Family Services (IDHFS) has contracted with McKesson Health Solutions to administer the program. Provider and patient participation is voluntary; individuals eligible for the Your Healthcare Plus Program may "opt out." Currently, the program serves approximately 253,000 individuals, including: 1) disabled adults who have been diagnosed with a chronic condition such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, end stage renal disease, hemophilia, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), malignancy, mental health, or other co-occurring conditions; 2) children and adults who have persistent asthma (as defined by the Health plan Employer Data and Information Set (HEDIS)); 3) children and adults who are frequent emergency room users (defined as six or more visits a year); and 4) individuals in the elderly (aged 65 and older) and the physically disabled Home and Community Based Waiver programs (waiver clients added to Your Healthcare Plus July 1, 2009.) Information about the disease management program is found at www.hfs.illinois.gov/dm.

Health Maintenance Organizations (HMOs) -- Enrollment in HMOs in Illinois continues to decline. In 2005 (the most recent data available), 12.5 percent of the state's population was covered by an HMO. There were 29 licensed HMOs in the state in 2004. The 10 largest HMOs covered 1.5 million persons in 2005, a 38 percent decrease from the 1999 peak of 2.6 million. Four of the 10 largest plans have enrollments in excess of 100,000 persons: Health Care Service Corporation, Health Alliance Medical Plans, Humana Health Plan, and Unicare Health Plans. These four HMOs have enrolled about 1.1 million persons, or 70 percent of the total. Changes in hospital ownership have not affected affiliation agreements for the regionalized perinatal care system. The number of hospitals providing obstetrical care has been declining; currently 133 hospitals are licensed to provide this service.

Managed Care Organizations (MCOs) - Two MCOs participate in the voluntary managed care program for certain Title XIX and Title XXI participants in Cook County. One of those MCOs also serves certain Title XIX and Title XXI participants in St. Clair, Madison, Perry, Randolph, and Washington Counties. A new MCO contracted to participate in the voluntary managed care program to serve Rock Island, Henry, Mercer, Adams, Brown, Scott and Pike counties in the western part of the state in December 2008.

SERVICE DELIVERY SYSTEM - With the exception of the Teen Parent Services (TPS) program in part of Chicago, all of the primary and preventive care services in Illinois' Title V program are provided by grantees of the IDHS or the Illinois Department of Public Health (IDPH) grantees. Most often, these are local health departments. Community Health Centers also play an integral role in the delivery of primary and preventive care to pregnant women, mothers, infants, children, and adolescents.

Local Health Departments -- Local health departments were first established in Illinois by "AN ACT to authorize the organization of public health districts and for the establishment and maintenance of a health department for the same" (70 ILCS 905/1, effective July 1, 1917). Municipal health departments are governed by Section 17 of the Illinois Municipal Code of 1961 (65 ILCS 5/11 17 1). The statutory base for county and multiple county health departments (55 ILCS 5/5 25001) was revised July 1, 1990. Local health departments in Illinois are all tax supported to some degree. For county health departments, a local tax levy of as much as 0.1

percent of the assessed value of all taxable property in the county can be instituted through referendum; the actual rate is set, up to the legal maximum, through a vote of the county board (55 ILCS 5/5 25003 and 55 ILCS 5/5 25004). Currently, there are 47 "resolution" health departments (those established by resolution of a county board) and 48 "referendum" health departments. These health departments serve 99.7 percent of Illinois' population.

Community Health Centers - The Illinois Primary Health Care Association (IPHCA) reports there are 330 Community Health Centers, Federally Qualified Health Centers (FQHCs), or Healthy Schools Healthy Communities grantees. Many of these centers are maternal and child health grantee agencies providing primary medical care, dental care services, mental health/substance abuse services, obstetrical and gynecological care, or other professional services. Individual FQHCs receive grants for many MCH programs. The most significant collaboration is in the Chicago Healthy Start Initiative. The Winfield Moody Health Center, the Erie Family Health Center, and Henry Booth House are the medical partners for three of the four Healthy Start Family Centers. Erie Family Health Center, Lawndale Christian Health Center, and the Chicago Department of Public Health implement the Targeted Intensive Prenatal Case Management project in the city of Chicago, and Aunt Martha's and Chicago Family Health Center provide services on the far south side. The Southern Illinois Healthcare Foundation is a lead agency for HealthWorks of Illinois (HWIL). The Department is working with Lawndale Christian Health Center and PCC Wellness on the Healthy Births for Healthy Communities project.

ALLOCATION OF RESOURCES - The IDHS allocates its resources by "giving highest priority to those areas in Illinois having high concentrations of low income families, medically underserved areas, and those areas with high infant mortality and teenage pregnancies . . ." (77 Ill. Adm. Code 630.20 (a)(2)). Allocation decisions are made on the basis of competitive proposals, per capita allocations, or by other means. By federal law, IDHS allocates 30 percent to DSCC for CSHCN.

The distribution of resources in the state roughly parallels the distribution of live births. Table 1 (attached) presents the proportion of live births and the proportion of program resources allocated to groups of counties, ranked by the number of live births. For example, Group 1 includes the ten counties with the greatest number of live births (Cook, DuPage, Kane, Lake, Madison, McHenry, Peoria, St. Clair, Will and Winnebago). The proportion of MCH program grant funds allocated to these counties is roughly equal to the proportion of the state's live births that occur in these 10 counties. This pattern continues throughout the remaining groups of counties.

Table 1
Counties Grouped by Percent of Live Births and the Percent of MCH Program Grant Funds Awarded to Agencies in Those Counties: Illinois, SFY'10
Group of Counties Ranked by Live Births; Percent of 2008 Live Births; Percent of MCH Funds
1; 76 %; 80 %
2; 10 %; 10 %
3; 4 %; 4 %
4; 3 %; 2 %
5; 2 %; 1 %
6; 1 %; 1 %
7; 1 %; 1 %
8; 1 %; 1 %
9; 1 %; <1 %
10; < 1 %; 1 %

B. Agency Capacity

The State of Illinois has the capacity to provide comprehensive quality care to pregnant women, mothers and infants, children, adolescents, and women of reproductive age through strong mutually agreed upon relationships between the Illinois Departments of Human Services, Public Health (IDPH), Healthcare and Family Services (IDHFS) and the University of Illinois. (Org chart

attached.) The primary responsibility for Illinois' Title V program is that of the Division of Community Health and Prevention (DCHP) in IDHS. IDPH is responsible for the surveillance and policy infrastructure for health outcomes. The IDHFS underwrites access to health care for families in need. The needs of CSHCN are addressed by the Division of Specialized Care for Children, University of Illinois. The working relationships of these agencies are supported by interagency agreements that specify responsibilities in regard to service delivery, performance levels, data reporting, and data sharing. Although the working relationships are solid, data sharing. Presents challenges. State statutes, federal law (HIPAA) and interstate agreements are barriers to complete and smooth transfer of service delivery data. Illinois is addressing data sharing issues through various measures, most significantly the development of the Medical Data Warehouse (MDW). In 2005, the Illinois General Assembly passed and the Governor enacted Public Act 094-0267, the Medical Data Warehouse Act. The act authorizes the IDHFS to "perform all necessary administrative functions to expand its linearly scalable data warehouse to encompass other health care data sources at both the Department of Human Services and the Department of Public Health."

Multiple data sources will be consolidated into the MDW in an effort to provide a complete picture of publicly-funded programming and to reduce duplication of data and/or conflicting information that currently exists in the various databases. The process (which deals with extraction, transformation, cleansing, loading, and then maintaining the data in the MDW) will provide for high quality data.

Interagency agreements identify the data to be shared and details how it may be used. Resulting from the agreements and the design of the MDW, there is a more holistic view of the Medicaid beneficiary as well as the MCH service recipient. This enables the signatories of the agreement to see the other benefits that individuals may be receiving and design approaches that would improve service delivery, while providing assurances that they will not be receiving overlapping or duplicative services.

STATUTORY BASE
The Prenatal and Newborn Care Act (410 ILCS 225) and the Problem Pregnancy Health Services and Care Act (410 ILCS 230) establish programs to serve low-income and at-risk pregnant women.

The Developmental Disability Prevention Act (410 ILCS 250) authorizes regional perinatal health care and establishes the Perinatal Advisory Committee (PAC). HJR0111 (adopted in 2010) urges the PAC to investigate how Illinois can reduce the incidence of preterm births and report its findings and recommendations by November 1, 2012. The Perinatal HIV Prevention Act (410 ILCS 335) requires testing and counseling women on HIV infection.

The Newborn Metabolic Screening Act (410 ILCS 240), the Infant Eye Disease Act (410 ILCS 215), the Newborn Eye Pathology Act (410 ILCS 223) and the Hearing Screening for Newborns Act (410 ILCS 213) authorize health screening for newborns. The Genetic and Metabolic Diseases Advisory Committee Act (410 ILCS 265) created a committee to advise IDPH on screening newborns for metabolic diseases.

The Illinois Family Case Management Act (410 ILCS 212) authorizes the Family Case Management (FCM) program and creates the Maternal and Child Health Advisory Board. The WIC Vendor Management Act (410 ILCS 255) "establish[es] the statutory authority for the authorization, limitation, education and compliance review of WIC retail vendors…" The Counties Code (55 ILCS 5) provides for the autopsy of children under age two years and reporting of deaths suspected to be due to Sudden Infant Death Syndrome (SIDS) by the county coroner. The Early Intervention Services System Act (325 ILCS 20) "provide[s] a comprehensive, coordinated, interagency, interdisciplinary early intervention services system for eligible infants and toddlers …" A recent Senate Joint Resolution created a taskforce to review current activities, fiscal practices and evaluation outcomes of the EI program.

The Child Hearing and Vision Test Act (410 ILCS 205) authorizes screening young children for vision and hearing problems. The Illinois Lead Poisoning Prevention Act (410 ILCS 45) requires screening, reporting, inspection and abatement of environmental lead hazards affecting children under six years of age.

The Alcoholism and Other Drug Abuse and Dependency Act (20 ILCS 301) authorizes substance abuse prevention programs. The Suicide Prevention, Education, and Treatment Act (410 ILCS 53) authorizes IDPH to carry out the Illinois Suicide Prevention Strategic Plan.

The Child and Family Services Act (20 ILCS 505/17 and 17a) authorizes the Comprehensive Community Based Youth Services program. The Probation and Probation Officers Act (730 ILCS 110/16.1) authorizes the Redeploy Illinois program and, along with the Illinois Juvenile Court Act (705 ILCS 405), the establishment of juvenile probation services. The Emancipation of Minors Act (750 ILCS 30) allows a homeless minor to consent to receive shelter, housing and other services."

The Specialized Care for Children Act designates the University of Illinois as the agency to administer federal funds to support CSHCN.

The Illinois Domestic Violence Act of 1986 (750 ILCS 60) defines abuse, domestic violence, harassment and neglect and other terms and authorizes the issuance of orders of protection. The Domestic Violence Shelters Act (20 ILCS 1310) requires the Department to administer domestic violence shelters and service programs.

The Reduction of Racial and Ethnic Disparities Act (410 ILCS 100) provides grants to individuals, local governments, faith-based organizations, health care providers, social service providers and others to "improve the health outcomes of racial and ethnic populations."

OVERVIEW OF PROGRAMS AND SERVICES - Illinois' Title V program focuses on the reduction of infant mortality; the improvement of child health (including CSHCN); and the prevention of teen pregnancy. Specifically:

Preconception - The IDHS' Family Planning and IDHFS' Illinois Healthy Women programs address preconception care through family planning services. Other initiatives include the Preconception/Interconception Care Committee (PICC) and the development of a preconception care risk assessment tool.

IDPH supports a statewide genetic counseling program through grants to medical centers for diagnostic, counseling and treatment services; grants to local health departments for genetic case finding, education and referral; and grants to pediatric hematologists. The Title V program also works with the March of Dimes on a statewide campaign promoting folic acid. The DCHP leads the state's "Fruits and Veggies -- More Matters" campaign.

Prenatal - Direct health care services are provided through funds to the Chicago Department of Public Health (CDPH) and the FCM program. Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: the WIC and Family Case Management (FCM) programs.

Targeted, Intensive Prenatal Case Management (TIPCM) projects seek to reduce infant morbidity and mortality and prevent low birth weight. Healthy Start projects serve six community areas in Chicago's inner city. IDHS works with IDPH to train prenatal care providers on prevention of perinatal transmission of HIV. In addition, IDHFS is working with IDHS and local providers to develop a high-risk prenatal care model targeted to women who have had or are at risk for poor birth outcomes.

IDPH administers the state's regionalized perinatal care system. Four levels of care are defined in administrative rule, with all facilities integrated into networks of care. Activities focus on improving the quality of perinatal care and increasing the proportion of very low birth weight infants who are born in Level II+ or Level III centers.

Infants and Young Children - The Title V program includes direct service, enabling, population based and infrastructure building initiatives for infants and young children. Newborns are screened for metabolic diseases and congenital hearing loss. The state has supported a metabolic screening program for more than 45 years and now screens for 36 disorders. Infants with positive results are followed through 15 years of age. DSCC supports diagnostic evaluations to determine whether the infant is eligible for the CSHCN program. DSCC provides care coordination and/or specialty medical care for eligible children. The Newborn Hearing Screening Program is jointly administered by IDHS, IDPH, and DSCC.

The Title V program includes six statewide programs for infants and young children. The FCM program serves low income families with infants and a limited number of children under five years of age who are at risk for health or developmental problems. FCM grantees can use some grant funds to pay for primary pediatric care for medically indigent children who are not eligible for KidCare or FamilyCare coverage. WIC also serves low-income children who are under five years of age and have a nutritional risk factor. The Part C EI program provides comprehensive services to enhance the development of children from birth through 36 months of age who have developmental disabilities and delays. The IDPH Illinois Lead Program directs the screening of children six months through six years of age for lead poisoning, collects all blood lead test results, and provides medical case management. The IDPH Immunization Program distributes vaccine, conducts surveillance for vaccine preventable diseases, investigates disease outbreaks, conducts educational programs, assesses vaccine coverage levels, conducts quality assurance reviews of providers enrolled in the Vaccines for Children (VFC) Program, maintains the statewide immunization information system (ICARE) and sets vaccination requirements for day care facilities, schools and colleges/universities.The Title V and the Bureau of Child Care at IDHS jointly support a statewide network of Child Care Nurse Consultants (CCNC) who train and consult with child care providers.

The High Risk Infant Follow up Program, a component of FCM, serves infants with a high risk medical condition identified through the IDPH Adverse Pregnancy Outcomes Reporting System (APORS). Infants and families who experience a perinatal death are referred to local health departments for follow up visits by registered nurses, which may continue until the child's second birthday. Healthy Families Illinois (HFI) reduces new and expectant parents' risk for child abuse/neglect through intensive home visits to improve parenting skills, enhance parent-child bonds and promote healthy growth and development. HealthWorks of Illinois (HWIL), another component of FCM, is a collaborative effort of IDHS and the Illinois Department of Children and Family Services (IDCFS) to ensure that wards of the state receive comprehensive, quality health care. The IDPH Early Childhood Caries (ECC) program integrates oral health into every WIC and Head Start program in Illinois. In addition, IDPH has a HRSA grant that focuses on the development of comprehensive dental services at the local level with a specific emphasis on early childhood caries. The goal of the Child Safety Seat program is a reduction in automobile related injuries and fatalities among children under the age of four. The program makes a limited number of car seats available at no charge to low income families. Families are given instruction in the installation of the car seat. The program also works with state and local agencies to conduct car safety seat checks. IDPH also provides funding to Sudden Infant Death Services of Illinois to provide bereavement services for families and risk reduction education for health care providers and consumers.

The Title V program includes four infrastructure development projects that affect young children. The Fetal and Infant Mortality Review (FIMR) project reviews fetal and neonatal deaths in Chicago to identify social risk factors and recommend preventive interventions. The Title V program and many providers and child advocates work with the Illinois Early Learning Council to

develop a comprehensive, coordinated system of high-quality preventive services for children before birth and through five years of age. Twelve All Our Kids (AOK) Early Childhood Networks were established by the Birth to Five Project to improve local systems of care for families with young children. The Enhancing Developmentally Oriented Primary Care (EDOPC) project identifies and overcomes the barriers that pediatric primary care providers face in conducting developmental, social-emotional, postpartum depression, and domestic violence screenings, making appropriate referrals and attending to parents' developmental concerns.

Middle Childhood - The IDPH Vision and Hearing Screening Program supports screening activities by local health departments, school districts or other contractors to identify children with possible problems. IDPH also coordinates ophthalmologic, optometric, otologic, and audiologic examination clinics throughout the state. The Dental Sealant Grant Program works with interested communities to establish school based programs for dental sealant applications, oral health education, outreach for All Kids enrollment, dental examinations, and referral for dental treatment needs. An oral health education curriculum for grades K-12 was evaluated by Illinois School Health Centers and is now offered through the sealant program communities for use in their schools. Coordinated School Health Program grants are provided to several local health departments and school districts to promote implementation of a Coordinated School Health Program model to address the health needs of students in grades K 12. The School Health program provides consultation and technical assistance to schools throughout the state and health care services to students in elementary and middle schools. Professional continuing education programs for qualified school and public health nurses, social workers, health educators, and school administrators are conducted annually. Childhood asthma demonstration projects in Chicago use peer or community health educators to empower communities to address this complex health issue.

Adolescents - The Title V programs for adolescents include direct health care services through School Health Centers; projects to prevent teen pregnancy; transition services for CYSHCN, family support programs for pregnant and parenting teens; positive youth development and juvenile justice programs. The School Health Centers promote healthy lifestyles through health education and comprehensive direct physical, dental, and mental health services. Services are provided by licensed professional staff or through referral to local health care providers. Health centers that meet established standards are enrolled as Medicaid providers.

The Teen Pregnancy Prevention--Primary (TPPP) program provides support for community-based planning to reduce teen pregnancy, sexually transmitted infections and the transmission of HIV. This is done through education, service delivery and referrals appropriate to the age, culture and level of sexual experience of youth in classroom or community settings. Providers focus on three of the six program components: sexuality education, family planning information and referrals, youth development, parental involvement, professional development (e.g. teachers) or public awareness.

Title V services for teen parents: The Teen Parent Services (TPS) program is mandated for parents under 21 who are applying for or receiving Temporary Assistance for Needy Families (TANF) and who do not have a high school diploma or its equivalent and/or who receive Medicaid, WIC, FCM, or Food Stamps. TPS helps participants enroll and stay in school, and to transition from TANF or other public benefits to economic self-sufficiency. The program also helps clients to access other IDHS services. The Parents Too Soon (PTS) program helps new and expectant teen parents develop nurturing relationships with their children, avoid or delay subsequent pregnancy, improve their own health and emotional development and promote the healthy growth and development of their child(ren). Four PTS program sites provide Doula services to provide emotional support to women throughout the antepartum and postpartum periods. The Responsible Parenting program helps adolescent mothers between 13 and 18 years of age to delay subsequent pregnancies, consistently and effectively practice birth control, obtain a high school degree, develop parenting skills, and cope with the social/emotional challenges of pregnancy and parenting.

DCHP provides prevention, diversion and intervention services targeting youth to support families in crisis, prevent juvenile delinquency, encourage academic achievement and to divert youth at risk of involvement in the child welfare and juvenile justice systems. DCHP provides support to the Illinois Juvenile Justice Commission, the Redeploy Illinois Oversight Board and the Illinois Juvenile Detention Alternatives Initiative (JDAI) Partners Group. The Division also funds community-based prevention initiatives and prevention training and education for youth in the areas of substance abuse and delinquency prevention, and volunteerism.

Children with Special Health Care Needs - The Title V program for CSHCN is operated by the University of Illinois at Chicago's (UIC's) DSCC. It serves approximately 24,000 children annually through the Core Program, the IDHFS Home Care Waiver Program, the SSI Disabled Childrens Program, and the Children's Habilitation Clinic.

The goal of DSCC's Core Program is to assure community based, family centered, and culturally sensitive provision of comprehensive care coordination services for eligible CSHCN and their families. Core Program services include comprehensive evaluation, specialty medical care, care coordination, and related habilitative/rehabilitative services appropriate to the child's needs, and financial support for those families who are financially eligible. The program serves children with impairments in the following categories: orthopedic, nervous system, cardiovascular, craniofacial deformities, hearing, organic speech, eye and urinary system, cystic fibrosis, hemophilia, and inborn errors of metabolism. Children with a potentially eligible condition receive diagnostic and care coordination services without regard to financial eligibility.

Initial diagnostic evaluation services are provided in part by a network of field clinics, consisting primarily of orthopedic clinics, administered and funded by DSCC, and through office visits with private physicians and other freestanding clinics.

DSCC has 13 regional offices with additional satellite offices. Care coordinators (nurses, social workers, and speech pathologists/audiologists) develop an Individual Service Plan (ISP) for each child or youth to identify needed services and financial support. With the parents' permission, the ISP is shared with the child's or youth's medical home provider and other providers.

Families of children requiring financial support must have a total income below 285 percent of the federal poverty level. All families must maximize existing health insurance benefits before financial assistance can be provided. Families of uninsured CYSHCN who meet All Kids financial requirements are required to enroll in All Kids in order to receive financial assistance from DSCC. Children/youth with All Kids coverage receive care coordination to assist them in accessing services and limited financial assistance for services not covered by All Kids.

DSCC employs several Spanish-speaking staff and has written materials available in Spanish. Families whose primary language is not English or Spanish may use the AT&T Language Line. In addition, the FAC membership represents multiple cultures in providing input into DSCC initiatives and materials.

DSCC operates the Title XIX Waiver for Home and Community Based Services for Medically Fragile/Technology Dependent (MF/TD) Children, which is administered through the IDHFS. The program provides care coordination and cost effective supportive home services to children with complex medical needs who would otherwise be at risk of prolonged institutionalization or re institutionalization in a hospital or long term care facility.

DSCC is the agency designated to administer the Supplemental Security Income-Disabled Children's Program (SSI-DCP). Children are determined to be medically eligible for this program through the Illinois Disability Determination Services (IDDS), which in turn refers SSI-eligible children to DSCC for further assistance. DSCC provides information and referral services to children who are SSI eligible by sending the family information in English and Spanish about the

DSCC Core Program, and provides a toll free number for information and assistance. DSCC telephones families with children ages three to four to offer assistance in linking to appropriate resources, including Part B Early Childhood and Pre-Kindergarten for Children at Risk. Families with children ages 14-16 who are SSI-eligible also receive a telephone call to offer assistance in linking them to appropriate resources, including transition planning resources.

The Children's Habilitation Clinic is located within the Children and Adolescent Center of the Outpatient Care Center, the UIC's comprehensive outpatient facility. This location allows clinic staff to collaborate with other sub specialists and with primary care physicians and nurse practitioners. Staff provides comprehensive diagnostic services and developmental management for children with complex disabling conditions through age 21.

DSCC co-sponsors the Institute for Parents of Preschool Children Who are Deaf or Hard of Hearing with IDPH, IDHS, the Illinois School for the Deaf, and the ISBE. This is a week-long educational program for parents of children, ages birth to five, who have a significant hearing loss. The Institute also provides multidisciplinary evaluations.

To promote access to medical homes for CYSHCN, DSCC facilitates Quality Improvement Teams (QIT) by providing a trained facilitator to promote quality improvement in primary care practice settings, and learning sessions for new QITs. CYSHCN who are not enrolled in DSCC and who are enrolled in the All Kids program have a medical home with a Primary Care Provider (PCP) through the statewide Primary Care Case Management (PCCM) Program with Illinois Health Connect.

DSCC is represented on the Illinois Interagency Council on Early Intervention (IICEI). Care coordination is provided for families with children jointly enrolled in DSCC and EI program to coordinate between EI and DSCC to meet the child's medical and developmental needs. DSCC financial assistance is provided for specified medical services for families who are financially eligible (i.e., surgery, medications, durable medical equipment and supplies).

As a member of the Illinois Interagency Coordinating Council on Transition, DSCC is collaborating to develop a statewide plan to improve access to and availability of comprehensive transition services. Council members sponsor an annual statewide conference for all transition stakeholders. Other members of the Council represent state agencies in the following areas: education, corrections, employment/training, health, and human services.

DSCC publishes two editions of the "Special Addition" newsletter annually, which focuses on state and local topics of interest to families of children and youth with special health care needs. The newsletter is mailed to 8,000 families and is available to the public on the DSCC website.

Other Services for Adults - The Title V program supports or collaborates with several programs for adults. Parents Care and Share of Illinois conducts support groups across the state for parents. The Bureau of Domestic and Sexual Violence Prevention administers domestic violence and sexual abuse prevention programs throughout the state, offering comprehensive, community based services that meet the immediate and long term needs of victims and their children.

Infrastructure Building - Strong Foundations is designed to develop a statewide system of home visiting. The Chicago MCH Mini Block Grant to the CDPH supports direct and enabling services to pregnant women, children, and women of reproductive age. Illinois' Title V program leads the work of the following advisory bodies and task forces: The Maternal and Child Health Advisory Board advises IDHS regarding the Family Case Management program and other activities related to maternal and child health and infant mortality reduction programs. The Family Planning Advisory Committee advises IDHS on family planning policy and program operations. The Universal Newborn Hearing Screening Advisory Committee, which advises IDHS, IDPH and DSCC on the newborn hearing screening program and develops training for hospitals, ensures referrals to the EI program and provides public information on congenital hearing loss. Illinois

Interagency Council on Early Intervention, provides advice to DHS' Early Intervention program. The Early Intervention Task Force (established for a limited time and as a separate body from the Interagency Council) is conducting a comprehensive review of EI system. The Nutrition Services Advisory Committee advises IDHS on operation of the WIC program and coordination of nutrition programs. The Illinois Juvenile Justice Commission assures that youth who come into contact or may come into contact with the child welfare and the juvenile justice systems will have access to needed community, prevention, diversion, emergency and independent living services. The Redeploy Illinois Oversight Board encourages the deinstitutionalization of juvenile offenders by establishing projects in counties or groups of counties that reallocate State funds from juvenile correctional confinement to local jurisdictions. The Domestic Violence Advisory Council advises the Department on domestic violence prevention and treatment. The Council on Responsible Fatherhood was created to study social policies and practices regarding the value that each parent brings to the family unit.

Illinois' Title V program is represented on the following advisory committees and task forces: The Medicaid Advisory Committee advises the IDHFS regarding the services provided under the department's Medical Programs. The Illinois Early Learning Council coordinates existing programs and services for children from birth to five years of age. The State Board of Health advises the Director of Public Health regarding the core functions of needs assessment, goal setting, policy development and assurance of access to necessary services. The Perinatal Advisory Committee advises the director of Public Health on the operation of Illinois' regionalized perinatal care system. The Task Force on Chronic Disease Prevention and Health Promotion makes recommendations to the director of Public Health regarding the structure of chronic disease prevention and health promotion and the integration of efforts to ensure continuity of purpose and the elimination of disparity in the delivery of care. The Health Data Task Force works to create a system for public access to integrated health data. Illinois Health Policy Center Advisory Panel develops health policy to address critical issues facing the state. The Illinois Local Food, Farms and Jobs Council was serves as a forum for discussing food issues, fosters coordination between local communities and sectors in the food system, builds local farm and food networks, supports and implements programs and services that address local needs. The Parents and Community Accountability Study Committee studies racial and socioeconomic issues related to children. The Committee of Cooperative Services advises the State Superintendent of Education on the statewide development, implementation, and coordination of alternative learning opportunities programs to improve the educational outcomes of students at risk of academic failure through the coordinated provision of education, health, mental health, and human services. The School Success Task Force makes recommendations related to current State Board of Education policies regarding suspensions, expulsions, and truancies. The Commission on Children and Youth is charged with creating a five-year strategic plan to provide services to youth 0-24 years.

Despite the numerous resources committed to improving maternal and child health, there are significant challenges to Illinois' ability to maintain the level of service delivery experienced by mothers, infants, children and adolescents in the past. At the state administrative level, individuals responsible for program policy and administration face staff shortages and salary cuts prompting several seasoned employees to leave public services. Efforts to fill vacancies continue in an environment of severe budget constraints. At the local level, many longtime MCH providers are divesting themselves of critical state-funded programs, (e.g. FCM and EI). Significant cuts in funding and delays in payment are the principle reasons cited.

CULTURAL COMPETENCE - The Title V program has several mechanisms to ensure that the assessment of need and allocation of resources at the state level and the delivery of services at the community level are culturally sensitive, relevant and competent. The Title V program analyzes and reports information by racial and ethnic subgroups in order to detect disparities in health status and allocate resources accordingly. The needs assessment presented with the FFY'11 application reflects more extensive participation by service providers and consumers than Illinois' Title V program has previously obtained. In addition, the State of Illinois has adopted

guidelines on linguistic and cultural competence "as a mechanism for improving language and cultural accessibility and sensitivity in State-funded direct human services delivered by human service organizations that receive grants and contracts to serve the residents of the State of Illinois." Each new Request for Proposals issued by the State requires potential vendors to present a plan for improving access to culturally competent programs, services, activities for LEP customers, persons who are hard of hearing or deaf, and persons with low literacy. Service providers must adhere to specific guidelines and provide to consumers in their preferred language both verbal and written notices of their right to receive language assistance services that are culturally appropriate. Finally, the DCHP's training contractors routinely offer cultural competence training to community-based providers.

C. Organizational Structure

Please see the attached organizational chart. The Governor has designated the IDHS as the state health agency responsible for the administration of the MCH Services Block Grant in Illinois (in a letter from Governor Edgar to Secretary Shalala, June 10, 1997). Through an interagency agreement, MCH Services Block Grant funds are transferred to the IDPH for the administration of the Vision and Hearing Screening, Oral Health, Genetics, Illinois Lead Program and Perinatal Care programs. In compliance with federal law, IDHS transfers 30 percent of Illinois' MCH Services Block Grant funds to DSCC for services to CSHCN. Copies of current interagency agreements are on file in the Division of Community Health and Prevention. Additional information about the structure of these three agencies is presented below.

The Illinois Department of Human Services - The IDHS is organized into six divisions. The Division of Community Health and Prevention (DCHP) includes the family planning, infant mortality reduction, early childhood services (Early Intervention), WIC, school health, teen pregnancy prevention, teen family support, child abuse prevention, substance abuse prevention, domestic violence prevention and intervention, sexual assault prevention and response, youth services, and delinquency prevention programs. The Division of Developmental Disabilities includes the SSI Disability Determination Service and programs for persons with developmental disabilities. The Division of Human Capital Development includes adult employment, income assistance, food and shelter, refugee services and child care and is responsible for the Department's local offices. One or more local offices, called Family and Community Resource Centers, are located in almost every county of the state. Staff in these offices perform intake and eligibility determination for TANF, Food Stamps, Medicaid, SCHIP and other programs. The Division of Alcoholism and Substance Abuse is responsible for substance abuse treatment services. The Division of Mental Health is responsible for the state's system of community-based mental health care as well as psychiatric hospitals. The Division of Rehabilitation Services oversees the state's system of care for persons (mostly adults) who are physically challenged.

The Division of Community Health and Prevention is organized into five functional areas: Reproductive and Early Childhood Services, Youth and Adult Services, Community Support Services, Fiscal Services, and Program Planning and Development. The responsibilities of each functional area are described below.

Illinois' Title V program is housed in the Reproductive and Early Childhood Services unit. The Bureau of Maternal and Infant Health is responsible for the Family Planning, Family Case Management, Chicago Healthy Start, Targeted Intensive Prenatal Case Management, Early Childhood Comprehensive System Development (including the AOK Networks and the Healthy Child Care Illinois project), Project LAUNCH, HealthWorks, Pediatric Primary Care, High-Risk Infant Follow-up, the Chicago Doula Project and Fetal and Infant Mortality Review programs, as well as the "Mini Block Grant" to the Chicago Department of Public Health. The Bureau of Part C Early Intervention is responsible for Illinois' services under Part C of the federal Individuals with Disabilities Education Act. The Bureau of Family Nutrition is responsible for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and related programs.

The Nutrition Services Section in the Bureau of Family Nutrition is comprised of regional nutrition consultants, a state breastfeeding coordinator, and a state nutrition coordinator. All are Registered Dietitians and most are Master's trained, with expertise in maternal and child health. The section provides consultation and technical assistance on nutrition issues for the WIC and other MCH programs. The Bureau of Community Health Nursing has a staff of Master's prepared Maternal and Child Nurse Consultants who are distributed regionally throughout the state. The MCH Nurse Consultants conduct confidential medical chart audits including evaluation of client assessments, and overall coordination of medical care. Services are delivered in a variety of settings including health departments, hospitals, child care facilities, perinatal centers, schools, specialty clinics, federally qualified health centers, and community-based agencies. They also provide in-service training, continuing education programs and technical assistance for local agency staff, and integrate nursing expertise with DCHP programs.

Within Youth and Adult Services, the Bureau of Child and Adolescent Health is responsible for the Teen Parent Services, Parents Too Soon, Healthy Families Illinois, School Health, Subsequent Pregnancy Project, Parents Care and Share, Teen Pregnancy Prevention, Responsible Parenting programs, child safety seat distribution and checks. The School Health program includes the Coordinated School Health program, School Health Centers and continuing education programs for school health personnel. The Bureau of Youth Services and Delinquency Prevention offers prevention, diversion and intervention services targeting youth to support families in crisis, prevent juvenile delinquency, encourage academic achievement and to divert youth at risk of involvement in the child welfare, and juvenile justice. The Bureau of Community-Based and Primary Prevention is responsible for the Teen Pregnancy Prevention -- Primary Program, as well as the substance abuse prevention program, delinquency prevention, and volunteerism. These programs all target the general population or those at some risk; are provided in multiple domains (youth, families, schools and community settings); are aimed at multiple age groups; and utilize a variety of approaches (e.g., parent education, positive youth development, etc.).

Each DCHP-funded provider is assigned a Community Support Services Consultant (CSSC) as their primary liaison to the Division. Each of the five DHS Regions has a Regional Administrator who oversees the activities of the CSSCs and is responsible for coordinating the delivery of needed supports to providers. Regional Administrators and CSSCs assure that support is provided to Maternal and Child Health programs at the regional and community level in a way that is sensitive to the needs of clients and communities. At the community level, this is accomplished by partnering with community-based agencies. Accountability for Division programs is accomplished by performing required compliance monitoring and quality review of Division programs. CSSCs are liaisons between communities and CHP programs, assuring that provider needs are assessed and met on an on-going basis, so that quality service delivery is consistently achieved.

The Bureau of Fiscal Support Services is responsible for preparing contracts with more than 600 organizations each year to implement the Division's programs. The Bureau manages funds from more than 40 General Revenue Fund appropriations and 30 federal grants, giving the Division the most complex budget in the Department.

The Program Planning and Development unit is responsible for strategic planning, development and submission of applications for federal and foundation funds, and providing the information required for managing the performance of the Division's programs. Within Program Planning and Development, the Bureau of Performance Support Services (PSS) performs a variety of activities related to the collection, maintenance, and evaluation of community health and prevention data, and the development and presentation of training sessions to enhance the skills of prevention service providers.

The Division's bureaus and regional consultants have established a statewide network of comprehensive, community-based systems of health and social services for women of

reproductive age, infants, children and adolescents to assure family-centered, culturally competent and coordinated services.

Information and Referral Helpline - The MCH Helpline staff answer two 800 lines: 1) 800/545-2200 (MCH); and 2) 800-843-6154, option #5 (IDHS Customer Service Line). The staff of two field about 1,000 calls per month, including Spanish-speaking calls. The MCH Helpline staff handle calls on a wide variety of health and human service needs. About 65 percent of the calls are from the general public, and about 35 percent are local agency personnel. The automated WIC/EI Referral Line assists approximately 1,700 callers per month with locating their local WIC and/or EI office.

The University of Illinois at Chicago Division of Specialized Care for Children - DSCC administers the CSHCN program. The DSCC Director reports to the CEO of the UIC Healthcare Systems. DSCC is staffed to accomplish its traditional role of providing care coordination, accessing financial support for needed services, and advocating for high quality specialty services for CSHCN. Through a network of 13 regional offices and over 30 satellite locations, DSCC maintains a strong focus on family centered, community based care coordination activities and local systems development within all 102 counties in Illinois.

The Director of DSCC has access to consultation and assistance from the University of Illinois at Chicago, including a school of public health and colleges of medicine, nursing, allied health professions and education, as well as numerous associated health facilities and programs. A statutory Medical Advisory Board composed of medical community leaders from across the state and a family representative meet three times per year to counsel the Director on program policy and activities. In addition, consultation and assistance is also available from the DSCC Family Advisory Committee (FAC) that meets three times per year and has family member representation from all 13 regions of the state. The FAC Chairperson also serves as the family member representative on the DSCC Medical Advisory Board.

Frequent, close liaison is maintained with all major public and private agencies involved in services for CYSHCN. DSCC has leadership and/or membership involvement with the following CYSHCN related programs or activities: Illinois Chapter of the American Academy of Pediatrics Committee on Children with Disabilities, the Illinois Maternal and Child Health Coalition, Illinois Interagency Council on Early Intervention, Coordinating Council on Transition, Brain and Spinal Cord Injury Advisory Council, Illinois Universal Newborn Hearing Screening Advisory Committee, Illinois Genetics and Metabolic Diseases Advisory Committee, IFLOSS (Coalition for Access to Dental Care), and the Healthy Child Care Illinois Steering Committee. DSCC has four delegates, including a staff parent representative, to the Association for Maternal and Child Health Programs (AMCHP). DSCC staff attend the annual meetings to stay abreast of national issues.

In addition to senior DSCC staff participation on interagency boards, councils and task forces at the state level, regional office staffs have developed and participate in numerous community working groups that involve local leaders and parent groups. These activities are exemplified by the regional staff involvement in the AOK Early Childhood Networks, the Illinois Project for Local Assessment of Needs (IPLAN) process, Early Intervention Local Interagency Councils and Transition Planning Committees.

The Illinois Department of Public Health - As a result of the reorganization of state human service agencies in 1997 (20 ILCS 1305), IDPH retains responsibility for the following statutes and MCH programs: the Phenylketonuria Testing Act, which supports the newborn metabolic screening program; the Counties Code, which supports the Sudden Infant Death Syndrome Program; the Illinois Lead, which supports the Childhood Lead Poisoning Prevention Program; and the Prevention of Developmental Disability Act, which supports the Perinatal Program. IDPH also operates the Vision and Hearing Screening Program, the Newborn Hearing Screening Registry and the Oral Health Program. IDHS and IDPH annually execute an interagency agreement regarding the coordination of MCH services provided or funded by each agency.

Illinois Department of Healthcare and Family Services (IDHFS) -- The IDHFS Bureau of Maternal and Child Health Promotion (BMCHP) has a focuses on preventive maternal and child health services and partners with other state agencies, advocacy groups, private funders, provider organizations, academia, and interested parties to achieve maternal and child health goals.

For additional information on Illinois' Maternal and Child Health Program, please visit the DCHP web site (www.dhs.state.il.us/page.aspx?item=31754), the DSCC web site (www.uic.edu/hsc/dscc), the Illinois Early Hearing Detection and Intervention Program www.illinoisoundbeginnings.org the IDPH web site (www.idph.state.il.us) or the IDHFS Bureau of MCH Promotion web site (www.hfs.illinois.gov/mch).

D. Other MCH Capacity

Illinois Department of Human Services. Myrtis Sullivan, M.D., M.P.H., was appointed Associate Director for Reproductive and Early Childhood Services, Division of Community Health and Prevention, and serves as Illinois' Title V Director. As Associate Director, Dr. Sullivan supervises the Bureau Chiefs of the four bureaus within that functional unit -- the bureaus of Family Nutrition; Maternal and Infant Health; Maternal and Child Health Nursing; and Early Intervention. In her position as Title V Director, Dr. Sullivan is responsible for developing Illinois' State Plan for maternal and child health, and the MCH Block Grant, Title X and Title XX funded family planning programs, and other federal grants; and for directing and coordinating the policy and activities required to carry out a statewide program in maternal health, family planning and child health including prenatal and pre-conceptional care, perinatal services, and MCH evaluation studies.

Dr. Sullivan received her M.D. and M.P.H. degrees from the University of Illinois at Chicago. She is a licensed pediatrician, and has an extensive background in Maternal and Child Health. She has served and worked in areas of pediatric emergency services, environmental health, asthma, breastfeeding promotion, and community-based collaborative research. Dr. Sullivan has authored and coauthored several books/chapters, journal articles, and various published reports and abstracts pertaining to health and medicine practices, pediatrics, and community-based collaboratives.

There are a total of 174 FTE positions in the Division of Community Health and Prevention. There are 78 FTE positions at the central office in Springfield. Regional staff are deployed as follows: Region 1 (Chicago) 60 FTEs; Region 2 ("collar counties" and northern Illinois) 10 FTEs; Region 3 (north central Illinois) 10 FTEs; Region 4 (south central Illinois) 5 FTEs; and Region 5 (southern Illinois) 11 FTEs. Regional staff are generally Masters prepared maternal and child health nursing consultants, nutrition consultants and regional representatives involved in quality assurance and technical assistance and support for local providers and communities.

The MCH Nurse Consultants carry out public health core functions of assessment and policy development, and work with individuals, families and communities at the local and state levels, to assure quality in delivering MCH clinical programs. They participate in assessing community needs, and provide professional direction and leadership to nurses and allied health personnel delivering technical assistance services. The MCH nurses provide consultation to contracting agencies and local health departments in developing quality assurance programs. They work with school based health centers in developing medical records systems, and implementing family planning services. MCH Nurse Consultants provide nursing expertise and leadership in updating standards and enforcing regulations (codes and contractual specifications, with emphasis on programs such as Title V, WIC, Title X, Title XIX, Title XX , health plan requirements for pediatric, perinatal specialists services and criteria for out-of --plan referrals, regional networks coordination for special populations. MCH Nurse Consultants participate in program management activities, including assessing, certifying, and assuring quality services delivery to seven clinical programs operated by the Division of Community Health and Prevention.

Mr. Thomas F. Jerkovitz, M.P.A, C.P.A. was appointed Director of DSCC on November 16, 2009. Mr. Jerkovitz received his B.A. and M.P.A from the Pennsylvania State University. Mr. Jerkovitz gained extensive knowledge and administrative experience with large, complex children's health programs through a longstanding career in Illinois state government. He served in the Governor's Office as Senior Policy Advisor for Health and Human Services. In addition, Mr. Jerkovitz spent time in the Governor's Bureau of the Budget as the Division Chief for the Medical, Child Welfare and Health and Human Services Programs with responsibility for policy direction and fiscal management. He also served as the Executive Director of the Illinois Comprehensive Health Insurance Plan (ICHIP), a high-risk health insurance pool which had an annual expense of $150.0 million and provided coverage for more than 16,000 individuals. Immediately before joining DSCC, Mr. Jerkovitz was the Director of Finance for Health Alliance Medical Plans, Inc.

Currently DSCC employs 180 FTEs to provide enabling services from local offices in the DSCC regional office system and 63 FTEs in the Springfield central administrative office. The administrative office located at UIC in Chicago employs 5 FTEs and CHC employs 4.2 FTEs. DSCC employs one full time Family Liaison who works with the FAC, trains care coordination teams and provides parent outreach. The University is currently operating under a hiring freeze due to the state's budget; DSCC is filling only those positions providing direct care coordination services.

E. State Agency Coordination

For a description of the organizational relationship among Illinois' human services agencies directly involved in the Title V program, please refer to "Organizational Structure," above. Interagency agreements among IDHS, IDHFS, IDPH and DSCC are on file at the Division of Community Health and Prevention's headquarters in Springfield.

Other Divisions within the IDHS. The DCHP collaborates with other Divisions within IDHS to improve the coordination and effectiveness of Title V programs, as follows:

DCHP and the Division of Human Capital Development collaborate to help TANF families through intensive casework services that connect them to IDHS programs and benefits and to local community resources where other services are provided. The two divisions also jointly finance Healthy Child Care Illinois, described later.

DCHP and the Division of Mental Health work to integrate service systems to provide mental health and support services to children and their families. Both Divisions are active participants in the Illinois Children's Mental Health Partnership and the Illinois Children's Trauma Coalition, and are involved in Illinois' "Project LAUNCH" grant.

To enhance continuity of care for CSHCN, DSCC collaborates with IDHS' Division of Rehabilitation Services in vocational rehabilitation services for clients; home services programs to avoid unnecessary institutionalization; education and habilitative services for children requiring education programming outside their communities; independent living programs; referral process for children determined medically eligible for SSI, and transition of DSCC Home Care Waiver children to the DRS Home and Community-Based Services Waiver Program.

Through systems change efforts, DSCC and DRS have increased collaborative efforts targeted at transition planning for YSHCN. Additionally, a three-agency agreement is in place between DSCC, DRS, and IDHFS to facilitate the transition of youth from the Home and Community Based Services (HCBS) waiver operated by DSCC for children who are medically fragile/technology dependent to the Home Services Program, another Home and Community-Based Services waiver operated by the Division of Rehabilitation Services.

Illinois' mechanism for families of individuals with developmental disabilities to make their needs

known and help them access services. PUNS continues to be used by the IDHS Division of Developmental Disabilities to identify and provide services to children and adults most in need. DSCC care coordination staff informs families about the benefits of completing a PUNS assessment and refers families to the intake entities in their area.

DSCC maintains a Memorandum of Understanding with the Part C Early Intervention program to coordinate activities and is designated in state law as a member of the Illinois Interagency Council on Early Intervention. In addition, DSCC provides training and technical assistance for Early Intervention Service Coordinators.

Through an interagency agreement, the Illinois School for the Deaf, Part C Early Intervention program, IDPH, ISBE, and DSCC collaborate to provide the annual Institute for Parents of Preschool Children Who Are Deaf or Hard of Hearing, to enhance the knowledge of parents of infants and toddlers and provide multi-disciplinary evaluation. Since 2004, DSCC provides family scholarships to families who attended the Institute to supplement the loss of income because of the weeklong commitment.

IDHS and DSCC coordinate with other State agencies as described below:

Illinois Department of Healthcare and Family Services - IDHS and IDHFS have an Interagency Agreement for the coordination of Title V, Title XIX, and Title XXI program activities. This agreement allows each agency to refer eligible clients to the other for services. The two agencies have a separate agreement for the Family Case Management initiative that enables IDHFS to claim federal matching funds through the Medicaid program for outreach and case management activities conducted by the FCM program. IDHS and IDHFS have arranged for local health departments to claim federal matching funds through the Medicaid program for local expenditures that support the FCM program.

Local MCH programs, including local health departments, family planning clinics, and WIC agencies are serving as outstations for initiating the All Kids (Title XIX and Title XXI) application process for children under 19 years of age, their caretakers and for pregnant women. An annual notice is mailed to all families eligible for Title XIX or Title XXI (except individuals residing in long-term care facilities) to inform them of the WIC program and provide them with the Department's Health and Human Services hotline number.

Public/Private Partnerships - IDHFS works with several private foundations to use grant funds to operate pilot projects to improve birth and health outcomes. The projects involve partnerships with academia, advocacy organizations, provider organizations, providers, and other state agencies. Each project includes an evaluation component to identify issues affecting quality of care or test the efficacy of a particular intervention in improving birth and health outcomes, before being considered for statewide implementation.

Perinatal Health Status Report - Public Act 93-0536 (305 ILCS 5/5-5.23, enacted August 18, 2003) requires the IDHFS to submit a biannual report to the General Assembly concerning "the effectiveness of prenatal and perinatal health care services reimbursed under this section [the Illinois Medicaid program] in preventing low birth weight infants and reducing the need for neonatal intensive care…" The most recent report, published January 1, 2010, reviews the current status of Medicaid initiatives to promote perinatal health, including planned pregnancies, preconception risk assessment, the Healthy Births for Healthy Communities interconceptional care pilot, a comprehensive perinatal depression initiative, smoking cessation, and breastfeeding. The 2010 report also includes IDHFS' plans for implementing three new models of care to improve perinatal health. Each model will utilize care guidelines, actionable steps, provider training, care coordination, and appropriate referrals. The preconception care model for all women will focus on promotion of preconception care, provider training, technical assistance, and patient education. The high-risk prenatal care model will target women who have had previous poor birth outcomes or who have risk factors that contribute to poor birth outcomes. Important

components of this model include a reimbursement strategy for care coordination and medical management of high-risk women, clinical indicators, provider feedback, patient education and engagement, case management that includes life and reproductive health goals, coordination with DHS' FCM program and integration with the Perinatal System. The high-risk preconceptional/interconceptional care model will target women who have had a recent poor birth outcome. The model will focus on health education, addressing chronic health conditions, assuring that women set reproductive and life planning goals, and increasing interpregnancy spacing through intensive pre- and interconceptional care interventions. The Perinatal Report can be viewed on the IDHFS Web site at: http://www.hfs.illinois.gov/mch/report.html

The IDHFS and IDHS partner with the University of Illinois at Chicago and the NorthShore University HealthSystem to operate a comprehensive perinatal depression initiative, including reimbursement for risk assessment, a consultation service, provider training and technical assistance, a perinatal antidepressant medication chart, a 24-hour crisis hotline, and treatment and referral resources.

The IDHFS and IDHS partner with the Illinois Children's Mental Health Partnership and the University of Illinois at Chicago to offer Illinois DocAssist, a psychiatric phone consultation for primary care providers, nurses, nurse practitioners and other health professionals to screen, diagnose and treat the mental health and substance use problems of children and adolescents up to age 21. The service is available to providers who are enrolled in any medical program administered by IDHFS. Illinois DocAssist provides problem-based consultations and continuing medical education (CME) credit for training on behavioral health topics via in person workshops and web-based clinical resources. The program also provides identification of community resources for children and adolescents who require assistance outside the primary care setting.

Fluoride Varnish for Young Children/Bright Smiles From Birth - IDPH, IDHFS and the Illinois Chapter American Academy of Pediatrics implemented a project to train physicians to apply fluoride varnish to young children (under age three who have at least four erupted teeth) in the course of regular well-child visits. The goal of the Bright Smiles from Birth (BSFB) pilot project is to improve access to dental care and reduce early childhood caries for young children (under age three). BSFB is currently operating in Cook County, the "collar counties," Rockford and Peoria. Providers (physicians, nurse practitioners, FQHCs and hospital outpatient clinics) are trained by ICAAP to perform oral health screening, assessment, fluoride varnish application, anticipatory guidance, and make referrals to a "dental home" for follow-up dental care, and establishment of ongoing dental services. ICAAP works in partnership with the American Academy of Pediatric Dentistry to perform the trainings. During calendar year 2009, approximately 4,000 unduplicated children under age three received a fluoride varnish application in a pediatric practice.

The initiative has proven successful in improving access to dental care and studies confirm that fluoride varnish application is effective at reducing early childhood caries in young children (under age three). IDHFS is working to spread this initiative statewide as an evidence-based practice to address and improve the oral health of young children. Additional information on this project is reported under State Performance Measure 13.

Assuring Better Child Health and Development (ABCD) III. ABCD is funded by the Commonwealth Fund and administered by the National Academy for State Health Policy (NASHP). Illinois was involved in ABCD II, the screening academy, and now in ABCD III. The project is focused on strengthening the capacity of Illinois' Medical Program to promote children's healthy development, including social emotional development, and care coordination among medical homes and needed follow-up care. Once a learning collaborative and policy change strategies have been developed and tested, those successful are spread statewide.

Enhancing Developmentally Oriented Primary Care (EDOPC). The ABCD quality improvement effort reinforced through the EDOPC project, which provides training and ongoing technical assistance to primary care providers. Based on the "Healthy Steps" model, the ICAAP, the

Illinois Academy of Family Physicians (IAFP), and Advocate Health Foundation, partner with private foundations and IDHFS to operate the project. The overall goal of EDOPC is to identify and overcome the barriers that pediatric primary care providers face in conducting developmental, social-emotional, perinatal depression, and domestic violence screenings and assessments, making appropriate referrals, and attending to parents' developmental concerns. The IDHFS' PCCM Administrator, Automated Health Systems, the Erikson Institute, the Illinois Association for Infant Mental Health and the Ounce of Prevention, and other private foundations and advocate groups, are involved in promoting the project. The EDOPC project helps Illinois' pediatric care providers through training, technical assistance and community support, and by implementing strategies to effectively provide developmentally oriented primary care. IDHS' MCH Nurse Consultants and FCM Coordinator have been trained on the Healthy Steps model of care and are working with the EDOPC project to provide training in communities throughout Illinois. Trainings have been provided for AOK networks, FQHCs, local health departments, and private provider practices.

Illinois (IDHFS) was selected to implement a CHIPRA Quality Improvement Project in partnership with Florida. The Illinois/Florida CHIPRA Quality Improvement Project will 1) test the collection of new CMS core measures and other selected supplemental measures of high priority; 2) collaborate with ongoing statewide Health Information Exchange (HIE) and Health Information Technology (HIT) development efforts to ensure that child health quality objectives are integrated, and child health performance measurement and quality improvement are fully supported; 3) support implementation of enhanced medical homes, through training and technical assistance for practice redesign addressing core medical home measures and creating strong referral and coordination networks, as well as through the integration of HIT; 4) evaluate the impact of the changes on the quality, coordination and efficiency of children's health care and in particular, children with special health care needs; and 5) build on measure development and HIT to support collaborative quality improvement projects to improve birth outcomes. IDHS is represented on the advisory committee for the CHIPRA project.

MCH Nurse Consultants coordinate with State funded agencies and CSSCs to manage and provide oversight to all CHP clinical programs. They utilize standards of professional performance and best practices to assure quality in the delivery of clinical services. Program management includes review and certification of the following programs: Targeted Intensive Prenatal Case Management, reproductive health programs, School Based Health Clinics, High Risk Infant Follow-up/APORS, Healthy Start, FCM, HealthWorks and Childhood Asthma. Monitoring is provided at least annually, in accordance with all applicable federal and state statutes and regulations. MCH Nurse Consultants also coordinate continuing education, workshops and seminars at which MCH issues are presented.

CSHCN - The IDHFS maintains an interagency agreement with DSCC, which includes a description of each agency's responsibilities in implementing the Home and Community-Based Services (HCBS) Section 1915 (c) waiver for medically fragile, technology dependent children under the age of 21. The agreement also facilitates claiming federal matching funds for care coordination under the HCBS waiver and for Medicaid-eligible children in DSCC's Core Program. The agreement is reviewed annually and updated as necessary. DSCC's responsibilities are outlined in detail in the agreement. DSCC provides care coordination, utilization review, and conducts quality assurance activities including oversight of nursing agencies and providers of durable medical equipment that serve the children in the waiver. IDHFS funds the program and maintains final approval of waiver eligibility, plans of care, and hearing decisions. DSCC is also an All Kids application agent. The IDHFS and DSCC meet at least quarterly to discuss policies and issues directly associated with implementing the HCBS waiver program.

Illinois Department of Public Health - IDHS and DSCC work with many divisions and programs within IDPH to serve women, infants, children, and children with special health care needs. IDPH and DSCC provide otologic/audiologic clinics in communities with high numbers of children who receive no follow up after failure of school hearing screenings. A Memorandum of Understanding

delineates collaborative services for children identified through the Newborn Metabolic Screening, Genetic Counseling, Vision and Hearing Screening, Hearing Instrument Consumer Protection, Universal Newborn Hearing Screening and Adverse Pregnancy Outcome Reporting Systems (APORS) programs.

IDPH, IDHS, and DSCC collaborate on the state's Universal Newborn Hearing Screening Program to enhance system development and implementation. DSCC has taken on responsibility for statewide system development activities related to this program. DSCC applied for and received the HRSA Universal Newborn Hearing Screening and Intervention Grant. The IDPH received a grant, the Early Hearing Detection and Intervention (EHDI) Tracking, Surveillance, and Integration Grant, from the Centers for Disease Control and Prevention (CDC).

In 1999, the IDPH received funding from the CDC to build capacity and to develop a state plan to address asthma. As a result, the Illinois Asthma Program (IAP) was formed and a statewide partnership was developed. The partnership meets twice a year, in addition to annual regional trainings and an annual asthma conference. Five workgroups and community asthma coalitions assist with the partnership's efforts. The IAP funds four coalitions to implement asthma state plan goals, and funds an additional 14 communities to develop asthma coalitions in order to raise awareness and education about asthma as well as to strengthen community resources. The IAP also funded 47 WIC clinics to provide asthma education to staff and clients.

IDHS works in collaboration with the IDPH's Illinois Asthma Initiative. The MCH program is represented at the advisory level, and on statewide subcommittees by Maternal and Child Health Nurse Consultants, Child Care Nurse Consultants, and School Health staff. In order to improve the management of childhood asthma, the resulting burden of acute care on healthcare facilities, and the high costs of children's education due to asthma related absenteeism, the IDHS supports two demonstration projects. These projects are administered by the University of Illinois at Chicago School of Public Health. First, the Childhood Asthma Initiative trains TANF-eligible parents of children with asthma as "asthma peer educators". These parents then assist other parents of children with asthma to successfully manage their children's illness. The training also provides them with marketable skills, thereby helping them toward financial self-sufficiency. Additionally, it collaborates with the "breath-mobile" asthma van to provide screening and referral services to Chicago Public School children and their families.

The second program is the Altgeld Gardens/Murray Homes Asthma initiative created to identify families with asthma diagnosis or asthma symptoms, and create linkages to healthcare services. Health educators and community outreach workers at the TCA Clinic collect baseline data from parents or guardians to establish a diagnosis of asthma related symptoms. Parents are selected and trained by the University of Illinois at Chicago, and Asthma screenings and follow-up services are delivered from mobile vans. Community residents at Altgeld who currently utilize the TCA health services are given the opportunity to receive treatment, education, and follow-up care in a special asthma clinic.

Illinois State Board of Education (ISBE) - DSCC care coordinators help families to understand their educational rights using "A Parent's Guide: The Educational Rights of Students with Disabilities," published by ISBE. DSCC regional office care coordinators work with the local schools regarding individual issues in the educational setting.

ISBE no longer employs a school health consultant; questions on school health related issues are referred to the IDHS School Health program staff and to the appropriate programs within IDPH. The School Health program staff worked with the ISBE and a State Advisory Committee to publish numerous documents, including: "Recommended Guidelines for Medication Administration in Schools;" "Asthma Management: A Resource Guide for Schools;" "Diabetes in Children: A Resource Guide for School Health Personnel;" "First Aid Procedures for Injuries and Illnesses;" "Certificate of Child Health Examination;" and "Health Status of School Age Children and Adolescents in Illinois." Copies of these documents have been sent to all public and private

schools in the state, as well as advocacy groups and individuals interested in these issues. The documents are also available electronically on the IDHS School Health Program web page. ISBE staff assist in the review of applicants for new School Health Centers and coordinated school health program grants.

Schools - A variety of programs are operated through schools to meet the needs of children and adolescents. First, the school health centers work through primary care providers to deliver comprehensive medical, mental health, dental and preventive health education services to school age children and parenting students. These clinics coordinate care provided to their clients with the clients' primary care provider. The clinics refer the client for specialty care as needed and seek third party reimbursement for services provided. Second, IDHS works with 12 local health departments to implement coordinated school health programs. Third, the MCH program also conducts continuing education programs for school nurses and administrators and provides regular updates on school health issues through email. Finally, schools are the main delivery sites for several programs, including Teen REACH, substance abuse prevention, Responsible Parenting and the Youth Opportunity programs.

Illinois Department of Children and Family Services - DCFS and IDHS collaborate on the operation of HealthWorks of Illinois, which establishes regional networks of primary and specialty care to ensure that children in foster care receive the health care services they require.

Illinois is one of seven states selected to pilot Strengthening Families through Early Care and Education. The DCFS initiated Strengthening Families Illinois through a collaboration of 30 partner organizations and state agencies in the fields of child welfare, child abuse prevention, and early childhood, along with parents and community leaders. Local learning networks have been established at five childcare centers across the state to work with families to build protective factors around children to prevent child abuse and neglect. The Child Care Nurse Consultants were trained to provide instruction about the protective factors to childcare providers throughout Illinois. Healthy Start and Targeted Intensive Prenatal Case Management staff received training on the Strengthening Families approach to client care in 2009.

DSCC collaborates with the DCFS on behalf of state wards who have special health care needs and are eligible for DSCC services. Coordination activities include identifying referral mechanisms for sharing information. To enhance system collaboration, DSCC staff are available to provide in-service training as needed on CSHCN to local and regional DCFS staff throughout the state. DSCC care coordination staff participated in DCFS online training for mandated reporters.

F. Health Systems Capacity Indicators

Introduction

The proportion of women who initiate prenatal care in the first trimester has been holding fairly steady in Illinois, and the proportion who receive an adequate number of prenatal care visits has been increasing. The proportion of Medicaid-eligible infants who obtain routine well-child care has exceeded 90 percent for the last five years. The high rates reflect the effort of several MCH programs. Appropriate care of asthma in young children and access to oral health care are two persistent health care system problems in Illinois. The proportion of state SSI beneficiaries under 16 years of age who received rehabilitative services through the CSHCN program was 9.5 percent.

The Illinois MCH program has extensive capacity to analyze data from vital records, program records, Medicaid and special surveys. The MCH program's primary information system, Cornerstone, includes immunization records from Medicaid-eligible children and paid claims for EPSDT services. Cornerstone is used to operate the WIC program and data from it is provided to the U.S. Centers for Disease Control and Prevention (CDC) annually for the Pregnancy and Pediatric Nutrition Surveillance Systems. The IDPH maintains a complete database of hospital discharges, maintains birth defects registry and conducts the PRAMS, the Youth Tobacco

Survey, and the BRFSS surveys for CDC.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	66.1	66.3	59.7	60.7	61.6
Numerator	5886	6024	5325	5429	5505
Denominator	890545	909278	891315	894368	893952
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Hospital discharge data that were made final and available in July 2010. The addition of additional diagnoses codes starting in 2008 only added a small percentage more than using the previous method of reporting.

Sources: IDPH Division of Health Policy, Facility Discharge Data. 2009 Illinois population estimates, US Census Bureau.

Notes - 2008
Hospital discharge data that were made final and available in 5/2009. The addition of additional diagnoses codes in 2008 only added a small percentage more than using the previous method of reporting.

Sources: IDPH Division of Health Policy, Facility Discharge Data. 2008 Illinois population estimates, US Census Bureau.

Update: final figures for 2008 revised 7/1/2010 with additional data from IDPH Division of Health Policy.

Notes - 2007
Hospital discharge data that were made final and available in 8/2008. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2006 Illinois population estimates, US Census Bureau.

Narrative:
In 2009 (the most recent data available), the rate of asthma hospitalization among children under five years of age was 61.6 per 10,000 residents. Although slightly higher than the rate reported in 2007 and 2008, it is a distinct improvement as compared to earlier rates. Overall, hospitalization rates for the period 2000-2009 continue to decline. The increase in the rates in 2008 and 2009 can be in in small part attributed to a change in the data collection and reporting mechanism used by IDPH. In both years an additional 16 diagnoses codes were added as the electronic Hospital Reporting system (known as e-Codes) was implemented. The MCH program supports a demonstration project to improve asthma management in young children; this activity was described earlier in the application.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.2	87.3	86.2	84.9	86.3
Numerator	64135	66245	71434	71391	71236
Denominator	73578	75921	82892	84052	82577
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. CMS-416 report (CMS-416_HCFA_Format) - HFS Continuously Enrolled Recipients.

Provisional for 2009 received in May 2010.

Notes - 2008
Source: Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. CMS-416 report (CMS-416_HCFA_Format) - HFS Continuously Enrolled Recipients.

Final for 2008 received in May 2010.

Notes - 2007
Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Data from report used to prepare the CMS 416 report. Received from IDFHS 7/9/08. 2007 data are provisional.

MCH has not received final data for 2007 as of May 2009.

Narrative:
The proportion of Medicaid-eligible infants who obtain routine well-child care is large - 95.9 percent of HFS continuously enrolled children (Title XIX, Title XXI, and state-funded only) through 15 months of age received at least one well-child visit in 2009. From 2008 to 2009, the number of < 1 year olds eligible for IDHFS services (Title XIX, Title XXI, state-funded only) decreased by 2,576 infants (percent change of -2.7). However, the total number of those ages < 1 through 20 years eligible for IDHFS services increased by 99,159 children (percent change +6.1). Identification of a medical home is a key measure in assuring that infants receive well-child visits. It is required that all infants enrolled in Family Case Management, Healthy Start, and HealthWorks have an identified primary care provider. Case managers in these programs provide education to the mother on the importance of well-child care, and monitor mother's compliance in completion of these visits. Case managers request documentation of same from the mother and/or the provider or the state HFS Medi-system. Information is then entered into the Cornerstone data system . Quarterly performance reports on the above mentioned programs are used to track an agency's performance.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	97.5	97.2	87.6	87.6	85.0
Numerator	842	1009	2718	2854	2520
Denominator	864	1038	3102	3258	2965
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Illinois Department of Healthcare and Family Services. Report - IHFS IDPAEIS100 - Well Child Visits in the First 15 Months of Life (W15) -
HFS Continuously Enrolled Recipients. This HEDIS measure is used since it is reported to Federal CMS for Title XXI. Received May 2010.

2009 data are provisional.

Notes - 2008
Source: Illinois Department of Healthcare and Family Services. Report - IHFS IDPAEIS100 - Well Child Visits in the First 15 Months of Life (W15) -
HFS Continuously Enrolled Recipients. This HEDIS measure is used since it is reported to Federal CMS for Title XXI. Received May 2010.

Notes - 2007
Source: Illinois Department of Healthcare and Family Services. Report - IHFS IDPAEIS100 - Well Child Visits in the First 15 Months of Life (W15) -
HFS Continuously Enrolled Recipients. This HEDIS measure is used since it is reported to Federal CMS for Title XXI. Received May 2010.

Note that the 2007 figure was revised due to better data than was available previously.

Narrative:
Until 2004, fewer than 300 infants a year were eligible for SCHIP for at least 30 days. Enrollment in SCHIP in 2009 among those < 1 year of age was 9,606, and 86.1 percent of these infants received at least one well-child service. Note, this data is provisional since providers have up to one year following the date of service to submit claims.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	80.2	79.9	80.0	80.5	80.5
Numerator	133556	135403	132894	129840	

Denominator	166527	169481	166171	161341	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data are not available from IDPH for 2009 births. IDHS has no control over the processing or release of the State of Illinois Birth File. Therefore the rate for 2009 uses the rate from 2008 as an estimate. The approximate due date of the 2009 Birth File is May 2011.

Notes - 2008
Source: 2008 Birth file - IDPH, Vital Statistics.

Notes - 2007
Source: 2007 Birth file - IDPH, Vital Statistics.

Narrative:
The proportion of women who received an adequate number of prenatal care visits has been steadily increasing, as measured by the Kotelchuck Index. Despite the slight declines in 2006 and 2007, the long-term trend remains positive. Since 2003 the indicator has risen by an average of 0.5 percent in each of the succeeding years from 78.2 percent to 80.5 percent in 2008.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	71.1	70.0	68.4	76.2	77.1
Numerator	713621	754192	711502	868314	955198
Denominator	1003893	1078065	1039872	1139947	1238587
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Illinois Dept. of Healthcare and Family Services - IDPAEIS110 - Child Access to Primary Care - HFS Continuously Enrolled Recipients. The data include Title XIX only. Report ran 5/18/2010. 2009 data is provisional.

Notes - 2008
Source: Illinois Dept. of Healthcare and Family Services - IDPAEIS110 - Child Access to Primary Care - HFS Continuously Enrolled Recipients. The data include Title XIX only. Report ran 5/18/2010.

Notes - 2007
Source: Illinois Dept. of Healthcare and Family Services - IDPAEIS110 - Child Access to Primary Care - HFS Continuously Enrolled Recipients. The data include Title XIX only. Report ran 5/18/2010.

Narrative:
Based on the EPSDT participation report (Title XIX, CMS 416, Line 10), between 2008 and 2009, there was a percent change increase of 0.9 in the number of children from < 1 through 20 years of age receiving at least one screening.

Efforts to improve the EPSDT participation rate include the mailing of annual notices to families with children, and separate notices when a child is due for a screen, based on the periodicity schedule. IDHFS' medical home initiative, Illinois Health Connect (IHC), provides monthly panel rosters to primary care physicians (PCPs) that identify patients and whether the patients have received certain clinical services. PCPs receive bonus payments by meeting or exceeding benchmarks for particular services, including the percent of children in the practice who receive designated immunizations by age 24 months, and the percent of children in the practice who receive at least one objective developmental screening by and between certain age ranges. IHC also conducts outbound calls to remind clients when they are due for services. IHC will assist clients in scheduling an appointment with the child's PCP and will send a reminder notice 7 days prior to the appointment. In addition, DentaQuest contacts clients who have not received a dental service in the past year and inquires about barriers to dental treatment.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	47.4	52.2	54.8	58.4	61.3
Numerator	131667	161447	155797	173817	197599
Denominator	277819	309570	284306	297785	322568
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: Illinois Dept. of Healthcare and Family Services - MERA report "CMS416_HCFA_Format" for EPSDT participation. Report ran 5/18/2010. 2009 data is provisional.

Notes - 2008
Source: Illinois Dept. of Healthcare and Family Services - MERA report "CMS416_HCFA_Format" for EPSDT participation. Report ran 5/18/2010.

Notes - 2007
Source: Illinois Dept. of Healthcare and Family Services - MERA report "CMS416_HCFA_Format" for EPSDT participation. Report ran 5/18/2010.

Narrative:
The proportion of Medicaid-eligible children between 6 and 9 years of age who received any dental services reached 57.8 percent in 2008, a significant increase when compared to earlier years. That figure remains constant for the 2009 period.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	11.6	8.3	8.7	10.2	9.5
Numerator	4649	3155	3286	3854	3608
Denominator	40110	37981	37673	37755	37900
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The annual indicator is an estimate that includes two populations served by DSCC, including children who were newly eligible for SSI who receive information and referral services and SSI eligible children who also receive services through the Core and Home Care Program. Some number of children could be dually counted in these two groups.

Narrative:
Children with Special Health Care Needs. The proportion of state SSI beneficiaries under 16 years of age who received rehabilitative services through the CSHCN program (HSCI 8, Form 17) was 9.5 in 2009. For a description of DSCC's efforts for SSI-eligible children, see Section III.B., "Agency Capacity," "Children with Special Healthcare Needs."

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	matching data files	9.8	6.9	8.4

Notes - 2011
Source: 2008 Birth file from IDPH matched to Medicaid data by IDHS, Community Health & Prevention, Performance Support Services, August 2010.

Narrative:

In 2007, the percent of low birth weight births was higher among Medicaid-eligible infants (9.1 percent) than non-Medicaid eligible infants (7.5 percent). The percent distribution of low-birth weight among Medicaid and non-Medicaid infants is similar to previous years in that it is higher among Medicaid-eligible infants

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	6.9	5.8	6.6

Notes - 2011
2007 Birth/death file from IDPH matched to Medicaid data by DHS, Community Health & Prevention, Performance Support Services, September 2009. 2008 data is not available at the time of this report submission. There is no indication from IDPH when the 2008 data will be available. An estimated due date is May 2011. IDHS has no control over the timing of the release of this data.

Narrative:
As in previous reports, the rate of infant mortality is higher among Medicaid-eligible infants (6.9 deaths per 1,000 live births) than non-Medicaid-eligible infants (5.81 deaths per 1,000 live births). (CY 2007 data).

The Chicago Healthy Start Project, Targeted Intensive Prenatal Case Management and Healthy Births for Healthy Communities are DHS case management programs that target women at high-risk for poor pregnancy outcomes. The goal of these programs is to enroll the women early in pregnancy, connect her with needed medical and social services, monitor care throughout pregnancy, and encourage adoption of healthy lifestyle behaviors. In the past two years, there has been a growing focus on adoption of a lifecourse model, with recognition that good prenatal care alone is not enough to reduce the overall incidence of infant mortality.

There is a significant disparity between infant mortality rates of Caucasian and black infants in Illinois.

Increasing focus on preconception/interconception health has occurred across many of the MCH programs this past year. Educational sessions have been provided for Healthy Start and School Health staff, as well as staff from FQHC's and Title X agencies. Illinois began participation in a national Healthy Start Learning Collaborative focused on Interconceptional Health in 2009.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid,***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

non-Medicaid, and all MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	79.7	92.5	86.3

Notes - 2011
Source: 2008 Birth file from IDPH matched to Medicaid data by IDHS, Community Health & Prevention, Performance Support Services, August 2010.

Narrative:
Improvement in the percent of infants born to women receiving prenatal care in the first trimester was reported across income groups in 2005 as compared to 2004, and then again in 2006 as compared to 2005. However, the rate leveled off in 2007 before increasing dramatically in 2008, the most current data for the Medicaid-eligible population. The percent of births receiving prenatal care in the first trimester among Medicaid-eligible was 79.7 in 2008, 75.5 in 2007, 76.3 in 2006, 74.3 in 2005 and 71.9 in 2004. The percent among non Medicaid-eligible was 92.5 in 2008, 88.3 in 2007, 88.2 in 2006 and 87.4 in 2005.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files	73.7	85.9	80.5

Notes - 2011
Source: 2008 Birth file from IDPH matched to Medicaid data by IDHS, Community Health & Prevention, Performance Support Services, August 2010.

Narrative:
As compared to 2004, greater percentages of women regardless of payment source were receiving adequate prenatal care according to 2005 vital statistics data. That trend continued into 2006, however there was a modest decline in 2007 before a return to the levels in previous years for 2008. For Medicaid-eligible women, the percent receiving adequate prenatal care was 73.7 in 2008, 70.5 in 2004, 73.0 in 2005, 73.8 in 2006 and 73.4 in 2007. Non-Medicaid eligible women reported a modest increase in the percent receiving adequate prenatal care from 2004 to 2005, 86.6 to 87.4 percent, respectively, but then showed a reversal in 2006 with a rate of 88.2 percent, and then improved in 2007 with a rate of 86.8 but then reverted slightly in 2008 with a rate of 85.9. These observed increases were reflected somewhat in the percent differences for the entire

birth cohort; in 2004, 78.8 percent of pregnant women received adequate prenatal care, in 2005 it was 80.0, in 2006 it was 79.9, in 2007 it was 80.0 percent and in 2008 it was 80.5 percent.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	133

Narrative:
Infants from families with incomes at or below 133 percent of the federal poverty standard are eligible for Medicaid and are covered through All Kids Assist if their mothers were not eligible for Medicaid during pregnancy. If their mothers were not eligible for Medicaid during pregnancy, infants from families with incomes above 133 percent and less than or equal to 200 percent of the federal poverty standard are eligible for CHIP. These children are covered through All Kids Share if their families' incomes are more than 133 percent and up to and including 150 percent of the federal poverty standard and All Kids Premium Level 1 if their families' incomes are more than 150 and up to and including 200 percent of the federal poverty level. Infants from families with incomes above 200 percent of the federal poverty level are not eligible for CHIP but may be covered through All Kids Premium (at a higher premium level). Refer to "Health Care Financing" in Section III.A. of this application.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	133

Narrative:
Children from families with incomes at or below 133 percent of the federal poverty standard are eligible for Medicaid and are covered through All Kids Assist. Children from families with incomes above 133 percent and less than or equal to 200 percent of the federal poverty standard are eligible for CHIP. These children are covered through All Kids Share if their families' incomes are

between 133 percent and 150 percent of the federal poverty standard and All Kids Premium Level 1 if their families' incomes are between 150 and 200 percent of the federal poverty level. These children may also qualify for premium assistance under All Kids Rebate. Children from families with incomes above 200 percent of the federal poverty level are not eligible for CHIP but may be covered through All Kids Premium (at a higher premium level). Refer to "Health Care Financing" in Section III.A. of this application.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	133

Narrative:
Pregnant women with family incomes at or below 200 percent of the federal poverty level are eligible for services under Medicaid. Women who are eligible for CHIP and become pregnant (all of whom are adolescents) are automatically deemed to be eligible for Medicaid. They are served through All Kids Moms and Babies. Refer to "Health Care Financing" in Section III.A. of this application.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS	3	No

Hospital discharge survey for at least 90% of in-State discharges		
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
Enhanced data integration is well underway in Illinois as evidenced by the data sharing interagency agreement, MDW and IDHS' role in both. Illinois is poised to conduct analysis and research using an immense data warehouse. Resulting reports and studies undoubtedly will bolster the state's Title V MCH Services Block Grant Application and establish direction for MCH program and policy decisions. Prior to that end, Illinois must develop capacity to "mine" the warehouse for pertinent data and approach the data from an epidemiological perspective. Ultimately, this is the purpose of Illinois' State System's Development Initiative.

The Department of Human Services (DHS) continues to export MCH service files from its Cornerstone system to the HFS Medical Data Warehouse (MDW).

Staff members of Program Planning and Development, IDHS, have security access to the MDW. In 2010, PPD staff used the Medical Data Warehouse to match Medicaid recipients with maternal and child health service data in the Cornerstone system. Because the MDW employs a sophisticated matching algorithm, results of the Medicaid/Cornerstone match demonstrated a marked improvement in the efficiency of the process as compared to results of the previous method of matching two distinct data files. A contract with the University of Illinois at Chicago (UIC), School of Public Health allows the MCH Director and PPD to explore and conduct several research priorities. Deborah Rosenberg, Ph.D., Research Associate Professor, Division of Epidemiology and Biostatistics is the principle investigator and reports to the MCH Associate Director. The UIC researchers are allowed to access the linked infant birth and death files that are kept on the MDW via a data-sharing agreement and file transfers from authorized IDHS staff.

Dr. Rosenberg is instrumental in the preparation of the MCH statewide needs assessment. In particular, she assisted in shaping the needs assessment timeline and process and developing the analysis plan. Dr. Rosenberg participated in the expert panel and stakeholders' meetings, helped create the final data books, synthesized qualitative and quantitative data and facilitated the priority-setting process.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	No
Youth Tobacco Survey	3	No
Illinois Youth Survey	3	Yes

Notes - 2011

Narrative:
The Illinois MCH program has extensive capacity to analyze data from vital records, program records, Medicaid and special surveys. The IDPH produces matched birth and death certificate files, although production is behind schedule due to staff shortages. The MCH program annually produces a file of matched vital records, Medicaid eligibility, paid claims and MCH program participation that allows comparison of natality characteristics among infants that were and were not covered by Medicaid or involved in any of several MCH programs. The MCH program's primary information system, Cornerstone, includes immunization records from Medicaid-eligible children and paid claims for EPSDT services. Cornerstone is used to operate the WIC program and data from it is provided to the CDC annually for the Pregnancy and Pediatric Nutrition Surveillance Systems. The IDPH maintains a complete database on hospital discharges, maintains birth defects registry and conducts the Pregnancy Risk Assessment and Monitoring System (PRAMS), the Youth Tobacco Survey, and the Behavioral Risk Factor Surveillance System (BRFSS) surveys for CDC.

IDHS, IDHFS, and IDPH are strengthening the state infrastructure for program planning and development through a three-way agreement for exchange of data for program planning, monitoring, and evaluation. The agreement involves the exchange of vital records, Medicaid eligibility and MCH service delivery, and other program management data. Records of vital events that occur in other states to Illinois citizens are governed by the Inter-Jurisdictional Exchange Agreement (IJA) administered by the National Association of Public Health Statistics and Information Systems. The IJA limits IDPH's ability to share vital records events that occur in other states unless specifically authorized by a state as set forth in the IJA addendum or unless written permission has been secured from the state. As a result, IDHS and IDHFS have direct electronic access to records of approximately 97 percent of the vital events that occur each year to the citizens of Illinois.

The State of Illinois is embarking on a project to design an information system that encompasses its entire human services delivery system. With leadership from Governor Pat Quinn, seven state agencies have prepared a Planning Advance Planning Document (PAPD) to examine the feasibility of developing an enterprise solution to support the essential tasks of service provision -- intake, assessment, application, eligibility determination, casework, and provider management. The departments participating in this project are the Departments on Aging, Children and Family Services, Commerce and Economic Opportunity, Employment Security, Healthcare and Family Services, Human Services and Public Health.

Illinois uses its application for SSDI funding addressed the need to develop capacity to "mine" IDHFS' Medical Data Warehouse for pertinent data and approach the data from an epidemiological perspective.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Illinois Title V program uses a performance management model to guide its program efforts. After choosing a set of priority needs from the five year statewide needs assessment, resources are allocated and programs are designed and implemented to address these priorities. These program activities are described and categorized by the four levels of the MCH pyramid: direct health care; enabling; population based; and infrastructure building services. Imbedded within the levels of service are sets of national core performance measures and eight state negotiated performance measures categorized into three types: capacity, process, or risk factor. Because of the flexibility inherent in the Block Grant, the program activities or the role that Title V plays in the implementation of each performance measure varies. The program activities, as measured by these core and negotiated performance measures, are expected to have a collective contributory effect that will positively impact the national outcome measures for the Title V program.

B. State Priorities

The role of the Title V program in Illinois is to empower communities to develop an appropriate infrastructure and to enable women and children, including children with special health care needs, to access the preventive, primary, and specialty services they require. To fulfill this role, the Title V program considers health status, demographic, health care financing, and legislative factors when setting priorities and developing new initiatives. The current priorities and corresponding initiatives of the Title V program include:

Using a life course perspective, the Illinois maternal and child health priorities are intentionally written to cover the entire MCH population. This approach acknowledges that health status is the sum of experiences over the life course and affirms the importance of integrating services. Elimination of disparities is a major focus and disparities will be addressed in the measurement, monitoring, and action steps for each priority. Finally, priorities are framed from a health systems rather than a health status perspective because it is through health systems change that Illinois Title V can expect to improve the health of women, children, and families in the state.

1) Improve Title V's capacity to collect, acquire, integrate/link, analyze, and utilize administrative, programmatic, and surveillance data.

2) Integrate medical and community-based services for MCH populations and improve linkage of clients to these services, particularly CSHCN.

3) Promote, build, and sustain healthy families and communities.

4) Expand availability, access to, quality, and utilization of medical homes for all children and adolescents, including CSHCN.

5) Expand availability, access to, quality, and utilization of medical homes for all women.

6) Promote healthy pregnancies and reduce adverse pregnancy outcomes for mothers and infants.

7) Address the oral health needs of the MCH population through prevention, screening, referral, and appropriate treatment.

8) Address the mental health needs of the MCH population through prevention, screening, referral, and appropriate treatment.

9) Promote healthy weight, physical activity, and optimal nutrition for women and children.

10) Promote successful transition of youth with special health care needs to adult life.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.9	99.6	99.7	99.8	99.9
Annual Indicator	99.9	99.8	98.1	98.2	98.6
Numerator	178700	176890	862	961	1634
Denominator	178872	177234	879	979	1657
Data Source				IDPH, Genetics	IDPH, Genetics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99	99	99	99	99

Notes - 2009
Source: IDPH - Genetics. Starting with CY 2007 data, the figures show the number of newborns with a positive screen that are followed until case closure. Previously the figures simply reported the number of infants screened versus infants born. The change was made upon the recommendation of a federal review team in August 2010.

Notes - 2008
Source: IDPH - Genetics. Starting with CY 2007 data, the figures show the number of newborns with a positive screen that are followed until case closure. Previously the figures simply reported the number of infants screened versus infants born. The change was made upon the recommendation of a federal review team in August 2010.

Notes - 2007
Source: IDPH - Genetics. Starting with CY 2007 data, the figures show the number of newborns with a positive screen that are followed until case closure. Previously the figures simply reported the number of infants screened versus infants born. The change was made upon the recommendation of a federal review team in August 2010.

a. Last Year's Accomplishments
More than 98 percent of the children screened received follow-up. Actual performance (98.6 percent) was below the goal of 99.9 percent. However, this was due to the indicator's numerator and denominator being revised to more accurately reflect the measure. This change was made at the recommendation of reviewers at the most recent annual review meeting. The new objective is 99%.

Each year, IDPH screens more than 165,000 newborns for more than 35 conditions (PKU, congenital hypothyroidism, galactosemia, congenital adrenal hyperplasia, biotinidase deficiency, hemoglobinopathies, amino acid, organic acid, fatty acid oxidation disorders, and cystic fibrosis). Of these, more than 300 are diagnosed with one of these conditions, and another 4,100 are found to have an abnormal hemoglobin trait (refer to Form 6 in Appendix B). Staff assure that each infant receives appropriate referral, diagnosis, treatment, counseling, and long term follow-up services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct hospital-based screening			X	
2. Laboratory results are reported to IDPH			X	
3. Parents and physicians are notified			X	
4. Local health departments are contacted when children can't be located for diagnostic testing			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Newborns are routinely screened for more than 35 metabolic disorders. Infants with a positive screening result are followed through diagnostic evaluation, and children diagnosed for some conditions are followed up through 15 years of age.

A vendor was selected to develop a web-based Newborn Metabolic Screening Data System that will have the capacity to interface with the birth record to ensure that all Illinois infants are screened. That contract was implemented in 2009 and the contractor is working to complete Phase 2 of a 3 phase plan for full implementation.

Chicago. CDPH Maternal and Family Planning programs routinely screen for inherited disorders in community health clinics, and provide genetics education and referrals. In calendar year 2008, 2,198 clients were screened for genetic disorders, and 281 screened positive. All were referred for follow-up and further evaluation. The Public Health Nursing program receives referrals for children up to one year old for genetic disorders, and provides home visits and referrals to family counseling and genetics follow-up.

Folic acid is offered to all prenatal clients in an effort to reduce neural tube defects.

c. Plan for the Coming Year

The IDPH Genetics/Newborn Screening Program will establish practices to ensure that every newborn in the state is screened. IDPH and DSCC will continue to partner in the care of children diagnosed with a metabolic or genetic disorder. A pilot testing period screening for lysosomal storage disorders (LSDs) will begin in November 2010, with statewide screening for the five LSDs beginning in June 2011.

It is anticipated that the data system for tracking current and newly added disorder testing will be fully implement in FFY2011. The lysosomal storage disorders pilot testing period will begin in

2010.

Chicago. CDPH will continue routine genetic screening and referrals for genetics follow-up. It will continue to provide March of Dimes information on benefits of folic acid through a variety of venues, including churches, clinics, beauty shops, nail salons and grocery stores.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**167015**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	166913	99.9	19	13	13	100.0
Congenital Hypothyroidism (Classical)	166913	99.9	182	109	109	100.0
Galactosemia (Classical)	166913	99.9	26	7	7	100.0
Sickle Cell Disease	166913	99.9	127	105	105	100.0
Biotinidase Deficiency	166913	99.9	10	1	1	100.0
Congenital Adrenal Hyperplasia	166913	99.9	433	12	12	100.0
Cystic Fibrosis	166913	99.9	722	58	58	100.0
Other Amino Acid Disorders	166913	99.9	27	7	7	100.0
Fatty/organic Acid Disorders	166913	99.9	111	27	27	100.0
Phenylketonuria	340	0.2	0	340	340	100.0
Other Amino Acid Disorders	35	0.0	0	35	35	100.0
Fatty/Organic Acid Disorders	75	0.0	0	75	75	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	60.6	60.6	60.8	60.3	60.3
Annual Indicator	60.6	60.6	60.3	60.3	60.3
Numerator					
Denominator					
Data Source				CHSCN SLAITS Survey	CHSCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60.5	60.5	60.7	60.7	60.9

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The 2005/2006 National CSHCN Survey found that 60.3 percent of families with CSHCN indicated that they are partners in decision making at all levels and are satisfied with the services they receive. This is a slight decrease from the 2001 survey results. DSCC supported participation by 13 families for 3 meetings of the DSCC FAC. The FAC reviewed 2-3 of the national performance measures for CSHCN at each meeting and provided ideas for program consideration. The FAC also provided input on efforts to revise the assessment and Individual Service Plan (ISP) and the Family Survey. In March, 2009, DSCC mailed the Family Survey to all families with children enrolled in a DSCC program and to families recently referred from SSI.

Families are also members on the Early Hearing Detection and Intervention (EHDI) advisory committee, the Integrated Systems grant advisory committee, The Illinois Interagency Council on Early Intervention and all of the Medical Home Quality Improvement teams (QITs). The DSCC Family Liaison meets with families before the initial QIT meeting to prepare them and explain their partnership role on the team.

The Newborn Hearing Reducing Loss to Follow Up grant has also provided some support to initiate Guide By Your Side (GBYS) family to family support in Illinois. Family Guides received training on the EHDI program and their role in supporting families with infants that referred from newborn hearing screening.

The Family Page on the DSCC website and the Special Addition family newsletter kept interested families informed of MCHB and DSCC initiatives and other resources. Special Addition was

published twice in this grant year.

The DSCC Family Liaison served on the Family-to-Family (F2F) Health Information Center advisory board and provided technical assistance to F2F staff as needed. He also continued to provide training on Family Centered Care and care coordination for new care coordination staff.

DSCC also supported families to attend workshops and conferences pertaining to their children's issues. Annually DSCC offers support for up to 13 families to attend the Statewide Transition Conference.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote family/CSHCN Program partnerships through the Family Advisory Council.				X
2. Promote family/physician partnership thorugh the Medical Home initiative.				X
3. Family education on state/federal activities through Special Addition/DSCC Family website.				X
4. Collaboration with the Family-to-Family Health Information Center to improve access to information.		X		
5. Collaboration with families in Individualized Service Plan development.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DSCC's collaboration with the IL F2F Center continues. The DSCC Family Liaison also worked with families and professionals from the Region 4 Genetics Collaborative MCHB grant to develop a resource guide for families on Medical Homes: http://region4genetics.org/Region4/medical_home_guide_survey.aspx. This guide was the topic of a presentation at the recent AMCHP conference in Washington DC.

The return rate of the DSCC Family Survey was 43 percent. Over 100 families requested to be contacted when they returned the survey. Issues regarding transportation, school and finding needed resources were discussed. Families also participated in four community forums around the state for input for the Needs Assessment.

Members of the DSCC FAC assisted on the selection of artwork for the 2010 Medical Home calendar that was supported by DSCC, Illinois Chapter of the American Academy of Pediatrics, the Illinois Department of Healthcare and Family Services and Illinois Health Connect. The calendar was distributed to thousands of families across Illinois.

The FAC provided feedback on new and revised materials developed to address Transition, including Milestones Skills Checklists and teaching sheets.

Guide By Your Side has 10 guides responding to families' requests for information and support. Over 70 families have been assisted in this first year.

DSCC continued to publish the "Special Addition" family newsletter twice a year.

c. Plan for the Coming Year
The DSCC Family Liaison and the FAC chairperson will continue to explore ways to increase participation, especially related to the cultural diversity of the DSCC FAC.

With continuation of funding of the IL Family-to-Family Health Information and Education Center the DSCC Family Liaison will continue to serve on the advisory board and assist where needed.

The family newsletter "Special Addition," will continue to be distributed every six months to DSCC families receiving services. The DSCC Family Liaison will continue to explore new ways of involving families regionally in activities where they will tell their stories about their involvement in receiving DSCC services.

Members of the DSCC Family Advisory Council will continue to assist DSCC on various reviews, including policies, procedures, and activities related to transition and medical home. Staff will explore alternative methods for obtaining input/feedback on the Block Grant. Staff will also explore with the FAC their interest in leadership development and resources to address this need.

DSCC Family Liaison will continue to maintain and update the DSCC family webpage where numerous resources and topics to assist families are identified.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50.7	50.7	50.9	45.1	45.3
Annual Indicator	50.7	50.7	45.1	45.1	45.1
Numerator					
Denominator					
Data Source				CSHCN SLAITS Survey	CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	45.3	45.5	45.5	45.7	45.9

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The Illinois Department of Healthcare and Family Services (HFS) as the state Medicaid agency continues to provide medical homes to children in the All Kids/Medicaid program through its Primary Care Case Management (PCCM) program, called Illinois Health Connect. Specific quality measures are monitored and reported to the primary care physician (PCP) for his/her panel of patients. See State Overview on Health Care Financing for a description of the program. Certain populations are excluded, including those on SSI, those involved with the Department of Children and Family Services (DCFS), and children served by Title V.

Phase II of the Illinois Medical Home Project (IMHP) collaboration grant between ICAAP and DSCC ended in September 2008. Based on the assessment tools utilized, both facilitated and non-facilitated Quality Improvement teams (QITs) showed benefit from the medical home model and participation in learning sessions. QITs assigned a facilitator held twice as many QIT meetings and accomplished more quality improvement activities. The Illinois Chapter of the American Academy of Pediatrics (ICAAP) in partnership with DSCC received funding through two Illinois-based trust funds to support the Building Community Based Medical Homes for Children (BCMHC) project and recruitment of practices was initiated. DSCC staff provided medical home training and consultation for The Autism Program (TAP) HRSA grant Health Services Facilitators. This grant, Improving Access to Community Care (IMPACC), provides resources for families and better connects service providers for children with Autism Spectrum Disorders (ASDs). The 7-C Medical Home Practice and Family Surveys, developed by DSCC, were adapted from the Center for Medical Home Improvement's Medical Home Index and Family Index to better correlate with the AAP characteristics of a Medical Home. The 7-C Medical Home Family Survey was evaluated in an article published in the June, 2009, issue of the journal, Managed Care, entitled "Evaluating the Tools Used to Assess the Medical Home". It was highly rated, but the need for reliability and validity testing was noted.

The medical home coloring contest was repeated this year to promote public awareness of the medical home concept, and the winning drawings were used to develop a 2009 Calendar. Two presentations at the annual statewide Transition conference were offered by DSCC staff to address Medical Home and the Online Care Notebook found on the AAP National Center for Medical Home Implementation web site. The first phase of the State Newborn Hearing Screening Grant was completed with three birthing hospitals and two affiliate hospitals participating. Strengthening the linkage to a medical home for timely follow-up in the screening and intervention process was one of the change strategies employed by teams along with sharing information with providers about newborn hearing screening, definitive diagnosis, and early intervention. ICAAP continued their partnership with Advocate Healthcare Systems Healthy Steps Program, the Illinois Academy of Family Physicians, and the Illinois Department of Healthcare and Family Services (HFS) on a project called Enhancing Developmentally Oriented Primary Care (EDOPC). This project is a statewide, comprehensive effort to increase primary care providers' use of validated tools for developmental, social-emotional, and maternal depression screening. A related effort focused on coordinating care between Early Intervention and the Medical Home. Trainings and tools were developed for PCPs and EI service coordinators.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Integration of the Medical Home into care coordination that includes reimbursement.		X		
2. Medical Home physician training opportunities/Medical Home monograph.				X
3. Statewide physician outreach.				X
4. Quality improvement technical assistance to physician practices.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

HFS promotes medical homes through the PCCM program. Ninety-four percent of children enrolled in DSCC have a PCP.

Results from the IMHP are in process for potential publication. Five practices started medical home QITs under the BCMHC project, four pediatric practices and one family practice site. Three other practices will follow as "shadow" practices, incorporating changes under the overall administrative system. The first Learning Session for this project was held on April 2010. DSCC staff provided ongoing support and consultation for The Autism Program (TAP) HRSA grant. Medical Home QIT facilitation continues for eight practices and technical assistance for one. These teams are submitting for reimbursement of care coordination activities from both DSCC and managed care. DSCC care coordinators are involved in the QITs to serve as a liaison and provide resource information. With collaborative work by the previous Director, fielding of the 7-C Medical Home Practice and Family Surveys is in process with the DSCC Family Advisory Council and pediatric practices through Florida Dept of Health. Conference. The third medical home coloring contest/2010 calendar was sponsored with IDHS, IDHFS, and ICAAP. DSCC serves on the Project Advisory Committee for the ICAAP Coordinating Care between Early Intervention and the Primary Care Medical Home Project.

c. Plan for the Coming Year

HFS will continue to promote quality medical homes through the PCCM program. Quality measures will be addressed more rigorously through the CHIPRA grant awarded to Florida and Illinois.

The five QITs in the BCMHC project will be meeting regularly with facilitation. The second Learning Session will bring all the QITs together for sharing successful improvement strategies and networking and is being planned for September 2010. DSCC will continue ongoing consultation and facilitation training for the Health Services Facilitators as they begin QITs under the TAP HRSA grant. One current Medical Home team will serve as a mentor team to new QITs with this TAP project. Following the collection of completed 7-C Medical Home Practice and Family Surveys, the results will be evaluated for validity and reliability through UIC College of Urban Planning And Public Affairs - Survey Research Laboratory. This year will be the final phase of the current Newborn Hearing Screening Reduce Loss to Follow Up grant with at least 3 new birthing hospitals participating. Tools and strategies developed by the hospital newborn hearing screening teams will be shared with the community-based medical home teams. For more about this grant, see NPM #12.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	53.3	53.3	53.5	59.3	59.5
Annual Indicator	53.3	53.3	59.3	59.3	59.3
Numerator					
Denominator					
Data Source				CHSCN SLAITS Survey	CHSCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	59.5	59.7	59.7	59.9	59.9

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The 2005/2006 National CSHCN Survey found that 59.2 percent of Illinois families with CSHCN reported that they had adequate private and/or public insurance to pay for the services they need. This was a 5.9 percent increase from the previous CSHCN Survey.

Approximately 5 percent of children enrolled in DSCC had no third party benefits during the last fiscal year. DSCC care coordination teams assisted uninsured applicants and recipients to apply for the state All Kids Program. All Kids is the state's integrated healthcare program for all children, including CYSHCN . All Kids encompasses Medicaid, the State Children's Health Insurance Program and state funded coverage for children regardless of income level, citizenship or immigration requirements of Medicaid.

For financially eligible families, DSCC assisted with the payment of private insurance co-pays and deductibles for specialty care, for care not covered by private or public insurance and for exceptions when care was needed to promote continuity of care.

DSCC's benefit management technical assistance unit assisted DSCC care coordination teams

through training and ongoing technical assistance to maximize available funding sources for needed services.

The Illinois Department of Healthcare and Family Services provided educational outreach to DSCC care coordination teams regarding the state's Health Insurance Premium Payment (HIPP) program eligibility and program benefits for CYSHCN. Care coordination staff assisted potentially eligible families to apply for the HIPP program which pays an individual's share of the private group or individual insurance premium to maintain access and funding of health care.

DSCC assisted the Family to Family Health Information and Education Center (F2F) with the development of a guide listing Illinois and national internet resources for families with insurance issues. DSCC provided technical assistance in the development of "A Guide for Families of Children with Special Health Care Needs, All Kids vs. COBRA Coverage, Which One Should I Pick".

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Benefits management technical assistance team.		X		
2. Referral to All Kids.		X		
3. Family benefits management resources/resource development.		X		
4. Benefits management training for care coordination teams and families.				X
5. Promote enrollment of uninsured CSHCN in All Kids		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Care coordination teams assist families in maximizing all funding sources for needed services and assist uninsured CYSHCN to apply to All Kids and Medicaid. For financially eligible families, DSCC assists with the payment of private insurance co-pays and deductibles for specialty care, for care not covered by private or public insurance and for exceptions when care was needed to promote continuity of care. DSCC's benefit management unit continues to assist care coordination teams through training and technical assistance.

Key outreach activities in collaboration with state agencies continue. A "Private Health Insurance" Seminar conducted for families with CYSHCN was sponsored by the Arc of Illinois and F2F. Staff from DSCC along with the Department of Insurance, Attorney General and Department of Healthcare and Family Services provided a panel of experts to facilitate understanding. F2F developed a brochure "Illinois Medicaid Information for Families of Children and Adults with Disabilities" and a Fact Sheet for CYSHCN requiring incontinence supplies. DSCC developed a guide, "Questions and Answers about Health Insurance," based on a document from the Agency for Healthcare Research and Quality and America's Health Insurance Plans with permission. The guide provides information on private insurance, public programs, resources and tips for working with insurance. The guide is available on DSCC's website and through DSCC Regional Offices.

c. Plan for the Coming Year
New care coordination staff will continue to receive training on maximizing public and private funding sources. Benefit management staff will provide technical assistance to care coordination teams for individual CYSHCN issues, monitor and analyze key legislation for impact on CYSHCN health care funding, provide outreach to key agencies and programs, collaborate with other key agencies and promote awareness of health care funding issues and opportunities. The benefit management staff will continue to disseminate the benefit management electronic newsletter for DSCC care coordination staff to provide current information on health insurance and public funding sources. In addition, an online training on health insurance appeals is being developed for care coordination staff.

For financially eligible families, DSCC will continue to assist with the payment of private insurance co-pays and deductibles for specialty care, for eligible care not covered by private or public insurance and for exceptions when eligible care is needed to promote continuity of care.

Staff will also monitor implementation of national health care reform legislation for impact on access to health care services for CYSHCN.

DSCC will also participate on a panel presentation regarding Health Care Reform sponsored by Family to Family and the Arc of Illinois.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	76.1	76.1	76.3	89.8	89.8
Annual Indicator	76.1	76.1	89.8	89.8	89.8
Numerator					
Denominator					
Data Source				CHSCN SLAITS Survey	CHSCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90.2	90.2	90.2

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
The 2005/2006 National CSHCN Survey found that 89.8 percent of Illinois families with CSHCN reported that the community-based services systems were organized so that they can use them easily. This was a 13.7 percent increase from the previous CSHCN Survey.

DSCC staff continued to coordinate and collaborate with state and local agencies to identify and resolve service gaps and duplication. DSCC staff also provided consultation to the Family to Family (F2F) Health Information and Education Center in Illinois and served on the Advisory Committee for the Center. Community system development efforts continued in all areas of the CSHCN Healthy People 2010 goals with emphasis on Medical Home, Transition, Newborn Hearing and Early Intervention. Please refer to NPM #3 for Medical Home activities, NPM #6 and SPM #10 for transition activities and NPM #12 for newborn hearing screening and follow up activities. DSCC continued to maintain two internet websites to which information and links were added or updated regularly, including information on Medical Home, Transition and Newborn Hearing and a variety of resources. The DSCC website is www.uic.edu/hsc/dscc, and the website specifically for newborn hearing screening is http://www.illinoissoundbeginnings.org/.

Efforts to assist families of children eligible for SSI in accessing necessary services continued with telephone contacts attempted for children ages 3 to 4 years and 14 to 16 years. DSCC mailed DSCC information (in English and Spanish) to families of children age 16 years or less that are newly eligible for SSI. DSCC's toll-free telephone number is also provided for families wanting assistance with accessing services.

DSCC staff provided care coordination to the families of more than 600 children who are technology dependent/medically fragile (TD/MF) to facilitate access to needed services through a Home and Community Based Services (HCBS) Medicaid waiver so these children can live at home with their families in their communities. Efforts continued to facilitate the transition of these children as they approach 21 years of age and need to move to programs for adults.

DSCC staff revised the assessment tools used by care coordination teams to determine families' needs, priorities, and resources, to be more comprehensive. The forms for documenting service plans used in coordinating care for eligible children were also revised. Training on the new tools/forms was provided to all DSCC care coordination teams.

DSCC staff assisted families without health insurance to apply for All Kids. DSCC worked to assure that DSCC children, all of whom are excluded from the Medicaid Primary Care Case Management (PCCM) program, are identified in the Medicaid and PCCM databases, so that these children can be disenrolled from that program and its requirements. DSCC provided a supply of DSCC Medical Home calendars to the PCCM contractor for primary care physicians to increase awareness of DSCC and Medical Homes. DSCC care coordinators assist all families with children enrolled in DSCC, including those in All Kids, to access primary and specialty health care services.

DSCC collaborated with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) on a proposal for the State Integrated System Implementation Grants for CYSHCN. The proposal, which emphasized medical home, transition and other system components, was approved.

Illinois' mechanism for families of individuals with developmental disabilities to make their needs known and help them access services, Prioritization of Urgency of Need for Services (PUNS), continued to be used by the IDHS Division of Developmental Disabilities (DDD) to identify and

provide services to children and adults most in need. DSCC care coordination staff informed families about the benefits of completing a PUNS assessment and referred families to the intake entities in their area.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Care coordination infrastructure for eligible families.		X		
2. Collaborative memorandum of understanding with agencies.				X
3. Mutual referral process with Early Intervention Program.				X
4. Collaborative efforts with state transition effort.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Integrated Systems grant enabled ICAAP to hire a Youth Services Specialist to focus on project efforts, particularly raising awareness about transition and disseminating products developed through the project. The Project Advisory Committee (PAC) was recruited and had its first meeting in October 2009. Membership includes three parents, three youth, IDHS-DDD, the Illinois Primary Health Care Association, the Illinois School Nurse Association, IDPH's Division of Oral Health, the Illinois Academy of Family Physicians, IDHFS, F2F, the Illinois Council on Developmental Disabilities, The Autism Project, and a pediatrician. An Integrated Services Committee (ISC) was also formed and met in February 2010. Members of this committee represent various programs involved in transition and meet to share information and coordinate the programs represented. DSCC's Associate Medical Director worked closely with ICAAP staff to develop partnerships in the medical community, assess the issues related to transition for PCPs implementing medical homes, develop educational sessions for conferences/meetings attended by physicians, and begin developing materials for physicians to use, e.g. outlines for standard problem lists, formats for summaries, outlines of common medical complications of developmental disabilities, and teaching materials for PCPs to use with patients. Project staff are participating in Jump Start Quality Improvement training in June 2010.

c. Plan for the Coming Year

DSCC will continue collaborative efforts with ICAAP and other stakeholders on the HRSA integrated systems grant. Four physician practices will participate in Quality Improvement Teams to specifically address improving transition efforts in their practices. Strategies and materials developed will be disseminated to other practices providing Medical Homes. Targeted technical assistance will be offered to PCPs interested in improving their ability to serve YSHCN in addition to educational offerings for PCPs generally. The Illinois F2F Health Information and Education Center will provide training to families on medical home and transition. The Arc of Illinois will also be subcontracted to enhance their database of services to improve medical home provider and family access to information on services in their communities. The PAC will meet twice to review progress and advise ICAAP and DSCC on this initiative. The ISC will meet monthly to promote information sharing among transition programs and coordinate efforts.

DSCC staff will continue to assist families needing support services for their children with developmental disabilities, including referral to PUNS. DSCC will also continue to assist families having children age 16 years or less, newly eligible for SSI, to connect with needed services. The

system of care coordination staff in 13 regional offices that serve CSHCN in their communities will continue to be supported by DSCC.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	5.8	5.8	5.9	44.2	44.2
Annual Indicator	5.8	5.8	44.2	44.2	44.2
Numerator					
Denominator					
Data Source				CHSCN SLAITS Survey	CHSCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	44.4	44.5	44.6	44.6	44.6

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
DSCC and the Illinois Chapter of the American Academy of Pediatrics (ICAAP) collaborated with many other stakeholders to apply for the State Implementation Grant for Integrated Community Systems for Children with Special Healthcare Needs (CSHCN). This three year grant, beginning June 1, 2009 through May 31, 2012, is funded by the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). This project will: Improve access to quality, comprehensive, coordinated, community-based services for YSHCN and their families by working in collaboration with state partners to provide resources and training to build medical homes and transition youth with special needs into adult service systems; inform primary care providers and families about the

medical home model and importance of family-professional partnerships; provide training and resources to build medical homes and transition youth with special needs into adult service systems; encourage family and youth involvement in systems change, and collaborate with state leaders and policymakers to implement medical homes, disseminate resource information, and measure impact.

DSCC staff again participated on the steering committee and subcommittees for the fourth annual Illinois Statewide Transition Conference, held on October 27-29, 2008 in Peoria, IL. This event attracted over 700 participants including students, family members, educators, health care providers and rehabilitation professionals. Dr. John Reiss from the Institute for Child Health Policy at the University of Florida presented a plenary session and a breakout session. The learning objectives for the 2008 health care track for health care professionals, youth and families included: discuss maximizing adolescent focused health care and describe the unique opportunities and creative strategies for intervention; recognize the interplay between health care vocational, educational and community life transitions and increase awareness of transition issues, best practices in planning and service delivery and identify resources to help fulfill aspirations of youth/young adults with (dis)abilities.

DSCC continued to increase community-based collaboration committed to developing a high-quality, well-coordinated, easily-accessible system of care within medical homes for young people with special health care needs around transition issues. A presentation on Strategies, Hands-on Tools & Referral Resource Information for Use with Adolescent Patients to Promote Successful Transition was provided for the Rockford Crusader's Clinic Medical Home Quality Improvement Team (QIT) staff, including physicians and nurses. A parent/caregiver workshop on Transition from Birth and Beyond at Lake Forest Hospital was attended by Medical Home QIT members and other area families and caregivers.

The Illinois Interagency Coordinating Council (IICC) on Transition continued to collaborate and met with the Illinois State Advisory Council on the Education of Children with Disabilities (ISAC). In June 2008, the joint committee and other stakeholders convened a workgroup to coordinate statewide initiatives to improve transition outcomes for youth with disabilities. The plan is being finalized for implementation. Also, the IICC initiated a Cross-Agency Coordination Task Force of state agency representatives to address tenets of HB 1117 to study "the implementation of a uniform age by which youth with a developmental disability or mental illness ‘age out' of programs administered by those agencies." The unpublished document contains an examination of ways to improve transition services to individuals diagnosed with a developmental disability or mental illness by studying the current literature on transition and making recommendations to the appropriate agencies and IICC.

Regional Transition Planning Consortiums continued to allow opportunities for networking, improved collaboration, and statewide information resource sharing.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participation on the Illinois Interagency Coordinating Council for Transition.				X
2. Transition training/technical assistance for care coordinators.		X		
3. Expansion of state data collection mechanisms.				X
4. Promoting awareness of transition issues/resources.				X
5. Participation in Annual Statewide Transition Conference planning group.				X
6. Expansion of partnership and alliances.				X

7.				
8.				
9.				
10.				

b. Current Activities
As part of the implementation for the Integrated Community Systems for CYSHCN grant, DSCC and ICAAP have increased collaboration with partnering organizations, opportunities to provide additional trainings, and support for youth with special health care needs to transition into the adult healthcare system and maximize their potential in adulthood. See NPM 5 for more about these grant activities.

Ongoing trainings for health care professionals, youth and families are provided through the Fifth Annual Statewide Transition Conference, Medical Home Quality Improvement Teams, the Pediatric Committee in Lake County, and The Arc of Illinois and The Autism Program of Illinois Annual Convention in April 2010. Also, as part of the Integrated Community Systems for CSHCN grant, a transition session has been scheduled for ICAAP's Annual Meeting in June 2010. A Medical Home Learning Session to include Transition-focused presentations and activities will be scheduled in the fall of 2010. DSCC also continues to participate on state and local councils/committees to continue collaboration with external transition partners to improve and sustain systems of care. The Illinois ICC and ISAC continue collaborating on transition issues.

c. Plan for the Coming Year
DSCC will continue to participate on the Project Advisory Committee (PAC) and the Integrated Service Committee (ISC) for the Integrated Community Systems grant. The goals of the ISC are to coordinate and integrate the efforts of state and community-based agencies in the area of transition, to identify successful strategies and promising approaches to improving access to services for youth in transition that can serve as a model for initiatives across the state, to increase the responsiveness of services and programs to the needs of youths and their families, to simplify the process for accessing services and increase families' access to accurate information about transition-related services, and to increase the number of youth who receive comprehensive transition planning assistance that includes consideration of health care issues that impact successful transition. This group will meet bi-monthly for the remainder of the grant period.

In year two the grant project staff and training consultants will develop three sets of trainings and resources. One is for adult primary care providers who are interested in accepting young adults with special health care needs into their practices. Staff and consultants will develop and provide resources (progress charts, problem lists, etc.) and direct clinical support as well as more general training and information about the transition process, office accessibility, working with families, and other topics. The second set of materials is for pediatricians and will focus on coordinating health care transition and preparing youth and families to transition to adult providers. This includes resources for creating a portable medical summary, addressing adult service needs, and teaching youth to take more responsibility for their health care. The third set will include patient education materials to assist youth and families with transition. These will be developed and tested to assess youth/family preparedness to make the transition to adult care and to identify gaps so a transition care plan can be implemented. ICAAP and DSCC will work with a group of physicians to pilot some or all of these draft trainings and resources and obtain comments and suggestions to improve our offerings prior to widespread dissemination.

DSCC will participate on the Illinois statewide transition conference steering committee and subcommittees with the sixth annual conference scheduled for October 24-26, 2010 in Effingham, IL. The health care track will provide information and training to healthcare providers and other stakeholders on healthcare transition; increase collaboration with transition partners to improve

and sustain systems of care; and improve access to high quality, developmentally appropriate healthcare.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84.5	85	87	79	81
Annual Indicator	84.8	81.9	78.5	78.7	75
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	81	82	82	82	83

Notes - 2009
Estimated Vaccination Coverage with 4:3:3:1:3 Among Children 19-35 Months of Age - National Immunization Survey. Provisional data during preparation of this application is available for Q3-2008 to Q2-2009. This report does not provide a numerator or denominator. The data are derived from telephone interviews of a selected sample of individuals.

Notes - 2008
Estimated Vaccination Coverage with 4:3:1:3 Among Children 19-35 Months of Age - National Immunization Survey. Final data for calendar year 2008. This report does not provide a numerator or denominator. The data are derived from a telephone interview of approximately 400 individuals.

Notes - 2007
Estimated Vaccination Coverage with 4:3:1:3 Among Children 19-35 Months of Age - National Immunization Survey. Provisional data during preparation of this application is available for Q3-Q2. This report does not provide a numerator or denominator. The data are derived from a telephone interview of approximately 400 individuals.

a. Last Year's Accomplishments
The most current release of the National Immunization Survey (NIS) results (July 2008-June 2009) indicate that series completion levels for Illinois are as follows: 4/3/1/3/3 series at 75 percent; 4/3/1/3/3/1 series reported at 71.6 percent. The NIS data for the Illinois federal project area that excludes the city of Chicago are as follows: 4/3/1/3/3 series at 74 percent. These series levels track additional vaccines that have been included in the Advisory Committee on

Immunization Practices (ACIP) recommended childhood immunization schedule.

IDHS, IDPH, and IDHFS have collaborated on a campaign to improve the immunization level of children participating in the WIC program. Local WIC agencies (most of which are local health departments) received regular reports from IDHS on the proportion of infants and toddlers in the WIC program who were fully immunized. In addition, IDPH provides funding to support immunization efforts in CEDA WIC agencies. During 2008, 85.7 percent of children ages 12-18 months served at one of 15 CEDA-operated sites met the 3/2/2 coverage and 83 percent of children ages 24-35 months met the 4/3/3/1 series coverage. Statewide, WIC children ages 12-18 months achieved 3/2/2 series coverage of 84.6 percent. This is an increase from the previous reporting period. Levels for 4/3/3/1 at 24-35 months of age remained stable at 77.6 percent. IDPH provides federal immunization grant funds to support Vaccines for Children Assessment, Feedback, Incentives and Exchanges (VFC-AFIX) and provider education initiatives through ICAAP, Rockford Health Council, CCDPH, Will County Health Department, Macon County Health Department, Madison County Health Department, and Peoria City-County Health Department. VFC operations require that a minimum of 25 percent of all enrolled providers receive a site visit annually. There are over 1,748 VFC enrolled provider sites (excluding Chicago) representing over 3,000 physicians. In addition, general revenue funds have been awarded annually since FY'01 to four agencies providing direct services to children in areas identified as high risk to under immunization or access to healthcare services as well as areas with identified health care disparities. However, due to reduction in overall GRF funds, these grants will not continue after FY10.

The VFC program was established to reduce or eliminate barriers to service and eliminate costs as a factor. However, it is not related to providing services to children only due to special needs. All children meeting VFC eligibility are covered. VFC allows children to receive immunizations in their medical home.

Chicago. Chicago's immunization rates remain below the national average and below the national goal of 80 percent for the 4/3/1/3/3/1 childhood series. As new antigens have been introduced, the uptake in Chicago has been strong and comparable to other states nationally. What continues to challenge the city's series completion rates is the 4th DTaP vaccination.

The CDPH provides federal funds to St. Bernard Hospital to operate the Baby Immunization Tracking System (BITS), which is designed to track infants born at the hospital through their first years of life or until their shots are up-to-date In 2009, 1,199 infants were born at the hospital and 100 percent received their "birth dose" of Hepatitis B vaccine before they were discharged.

CDPH's immunization Program operates nine walk-in immunization clinics that served over 5,014 children in 2008. For FY2007, 88.6 percent of two-year-olds were fully immunized in CDPH's Family Case Management, Public Health Nursing and community health clinics, an increase over 87.1 percent for FY2006.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The IDPH Immunization program distributes vaccines to local health departments and Vaccines for Children.			X	
2. The IDPH Immunization program assesses immunization levels of children served in public clinics.				X
3. The IDPH Immunization program directs additional resources to areas identified as “Pockets of Need.”			X	
4. Additional outreach activities are conducted by the Chicago Department of Public Health & community organizations or			X	

coalitions.				
5. IDHS monitors and distributes reports of immunization coverage of children in the WIC program.		X		
6. IDHS monitors immunization coverage of children in programs for infants, young children, and teen parents.		X		
7. IDHFS sends reminder notices to families.			X	
8. IDHFS collaborates with IDPH on Vaccines for Children.				X
9. IDHFS included childhood immunizations (by age 2) as a bonus payment strategy within the managed care program (MCO and PCCM). The measure of childhood immunization by 24 months in addition to immunization by 36 months will also be added.				X
10. IDHFS provides patient-specific feedback on immunization status to Primary Care Case Managers.				X

b. Current Activities

The IDPH Immunization program is federally funded and is authorized by Section 317 of the Public Health Service Act. Additional federal funds are awarded annually through the federal VFC program as established through OBRA93. The program operates the following: 1) distributes vaccines to public and private providers statewide; 2) conducts surveillance and investigates outbreaks of preventable childhood and adult diseases; 3) conducts mandatory assessments of vaccine coverage levels among various target populations; and 4) works with IDHFS to improve immunization levels among Medicaid-eligible children.

Chicago. CDPH supports "Keeping Immunizations Current for Kids" (KICK), which is a provider-based reminder and recall program. The KICK program is designed to increase immunization rates among African American and other minority children between the ages of 0-5 through a coordinated reminder/recall and outreach program. The Immunization Program operates nine immunization walk-in clinics that provide fast, free and friendly immunization services to children 0-18 years of age. The nine Fast Track clinics are located in seven community areas.

c. Plan for the Coming Year

IDHS, IDPH, and IDHFS will continue the WIC immunization campaign. Immunization records will be added regularly to the Cornerstone and ICARE systems from the Medicaid Management Information System and the immunization tracking software used by the Chicago and Cook County Health Departments. Quarterly reports on the immunization coverage of one and two-year-olds will be provided to local WIC agencies, with follow-up consultation and technical assistance from regional staff.

IDPH will conduct and review the annual IDCFS/IDHS child care and Head Start survey through a random selection method developed by CDC. The Immunization Program will also work with the Child Care Resource and Referral Networks to educate child care facility staff regarding implementation and enforcement of immunization requirements. IDPH will visit at least 25 percent of enrolled provider sites with VFC to determine VFC compliance and conduct assessment of practice coverage levels. IDPH will continue the annual quality assurance reviews to determine compliance with the Standards for Pediatric Immunization Practices. Quality assurance reviews will use the AFIX strategy as developed by CDC. IDPH has a grant agreement with the ICAAP to extend AFIX services and conduct peer provider education. This strategy will also promote "birth dose" Hepatitis B vaccine efforts as well as adolescent immunization services and promotion.

The immunization program received supplemental funding in 2009 as part of the American Recovery and Reinvestment Act (ARRA) to increase vaccine coverage among children, adolescents and adults. ARRA direct assistance vaccine is utilized at the 95 certified health departments and will continue through December 31, 2011 to promote and deliver vaccinations to

underinsured children and adolescents against varicella, meningococcal and pertussis disease.

In addition, IDPH-authorized health jurisdictions will also identify and promote pertussis (Tdap) vaccination to parents enrolled in WIC and Family Case Management programming operated by the health jurisdiction to reduce the risk of pertussis infections in newborns. Parents between the ages of 15 to 25 years will be the primary focus of this initiative, as the majority of reported infant pertussis in Illinois has occurred in households where parents fell in this age range.

ARRA-supplied vaccine will also be utilized to address selected vaccination needs of health jurisdiction staff.

Chicago. The CDPH Immunization Program will continue to intensify strategies to improve immunization rates in Chicago with the following current activities: outreach, Fast-Track clinics, the CareVan, the WIC Immunization linkage program, and partnership with St. Bernard Hospital. CDPH's Public Health Nursing, Family Case Management, Healthy Start and the community health clinics will continue to track immunization status of two-year-olds and provide immunizations as necessary.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	22	21	21	21	21
Annual Indicator	21.2	22.1	22.1	21.2	21.2
Numerator	5794	6120	5988	5653	
Denominator	273565	276507	270929	266679	
Data Source				IDPH, Center for Health Statistics	IDPH, Center for Health Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	21	21	21	21	20

Notes - 2009
Data are not available from IDPH for 2009 births. IDHS has no control over the processing or release of the State of Illinois Birth File. Therefore the rate for 2009 uses the rate from 2008 as an estimate. The approximate due date of the 2009 Birth File is May 2011.

Notes - 2008
Source: IDPH Birth for 2008, received May 2010. Denominator is Census population estimates for 2008.

Notes - 2007

Source: IDPH Birth for 2007, received May 2009.

a. Last Year's Accomplishments
The rate of births to 15 to 17 year-old women in 2008 was 21.2 per 1,000; a lower rate than that reported in 2007 (22.1 per 1,000) and slightly above Illinois' performance target (21 per 1,000). The birth rate among 15 to 17-year-olds has declined by 18 percent between 2000 and 2005. The birth rate has increased among whites (3 percent) and blacks (4 percent); and decreased by 1 percent in Hispanics.

Several programs in the Division of Community Health and Prevention work to reduce teen births. The Primary and Subsequent Teen Pregnancy Prevention programs provided services to 66,000 adolescents in SFY'09. The Teen Parent Services program helped more than 2,394 low-income teen parents work on finishing school and move from welfare to work in SFY' 09. The Parents Too Soon program helped more than 2,101 teen parents develop parenting skills, delay a subsequent pregnancy, and finish school. And the Family Planning Program provided comprehensive reproductive health services to 28,115 adolescents in 2009.

Chicago. In 2007, 2,311 teens aged 15 -- 17 years of age gave birth. This calculates to a rate of 20.7 births per 1,000 teens.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS awards grants for Primary Teen Pregnancy Prevention programs.		X		
2. IDHS awards grants for Subsequent Teen Pregnancy Prevention programs.		X		
3. IDHS monitors repeat pregnancy rates among the clients of programs that serve teen parents.				X
4. IDHS awards grants for Family Planning programs	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Primary and secondary prevention of teen pregnancy and sexual activity before marriage is being addressed by the routine activities of the PTS, TPS, TPP, School Health Centers, School Health, and Family Planning programs. School Health Centers (SHCs) conduct risk assessment of all regular clinic users and provide anticipatory guidance, treatment or referral for sexual health and contraceptive services are included.

Chicago. Through its Family Case Management, Public Health Nursing, outreach, Family Planning, Healthy Start, and Male Responsibility programs, CDPH continues to assure that services are provided so that initial and repeat pregnancies are prevented. The Male Involvement and Family Planning programs provide education to teens on abstinence; safe sex practices to avoid unintended pregnancy and sexually transmitted infections including HIV; contraception; the prevention of sexual coercion; domestic violence; and pre/inter-conception care including nutrition, exercise and avoidance of smoking, alcohol, and drug use.

Chicago Public Schools use various curricula for their sex education program, including those

from Planned Parenthood and those that have an abstinence-only focus.

c. Plan for the Coming Year
Reduction of teen pregnancy and sexual activity before marriage will be addressed by the routine activities of the PTS, TPS, TPP, SHCs, School Health, and Family Planning programs.

Chicago. CDPH will continue to address adolescent pregnancy through Family Case Management, Public Health Nursing, outreach, Family Planning, Healthy Start, and Male Responsibility programs. The Chicago Public Schools will continue to work with youth leaders and the Illinois Caucus for Adolescent Health to continue to implement and improve their sex education curriculum.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	27	27	27	28	28
Annual Indicator	27.0	27.0	27.0	27.0	41.5
Numerator	42219	42000	42000	42000	65000
Denominator	156370	155356	155356	155356	156512
Data Source				IDPH, Oral Health	IDPH, Oral Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	42	43	44	45	46

Notes - 2009
According to the IDPH, Division of Oral Health, the 2008-2009 survey of 3rd grade children showed 41.5 percent of 3rd grade children had sealants on at least one permanent molar tooth. Every year the MCH program has extrapolated this percentage to the statewide population of 3rd grade students located at the Illinois State Board of Education's website.

The very small underresourced public health program completes a statewide third grade Basic Screening Survey every five years based on the Association of State and Territorial Dental Directors and CDC guidance.

In 2009, 18,367 3rd grade children received sealants covered by IDHFS medical programs (Title XIX, Title XXI, and State Funded) - IDHFS Dental Claims Data from the Medical Data Warehouse.

Notes - 2008
According to the IDPH, Oral Health program, the next oral health state level 3rd grade survey is in progress for 2008-09. The 2004 through 2007 percentage is from its 2003-04 oral health survey results. Every year the MCH program has extrapolated this percentage to the statewide population of 3rd grade students located at the Illinois State Board of Education's website. Since the percentage has not changed, the MCH program is reporting last year's numerator and denominator.

The annual performance objectives for 2008-2012 have been adjusted one percent to correct a 'data alert' stating the state has already surpassed subsequent year's objectives. This has been true since 2005. The very small underresourced public health program completes a statewide third grade Basic Screening Survey every five years based on the Association of State and Territorial Dental Directors and CDC guidance.

Notes - 2007
According to the IDPH, Oral Health program, the next oral health state level 3rd grade survey is planned for 2008-09. The 2004 through 2007 percentage is from its 2003-04 oral health survey results. Every year the MCH program has extrapolated this percentage to the statewide population of 3rd grade students located at the Illinois State Board of Education's website. Since the percentage has not changed, the MCH program is reporting last year's numerator and denominator.

The annual performance objectives for 2008-2012 have been adjusted one percent to correct a 'data alert' stating the state has already surpassed subsequent year's objectives. This has been true since 2005. It is possible in the future that Illinois will have a more positive method of reporting these data as a state instead of relying on the data collection of a very small underresourced public health program.

a. Last Year's Accomplishments
Due to a more recent survey, Illinois revised its goal of increasing the proportion of third-grade children who have protective sealants on at least one permanent molar tooth. The state's actual performance was 41.5 percent. The large increase can be attributed to the fact that the 2008-2009 sealant survey was the first one conducted since 2005. Also, the expansion of child health insurance programs offered by the state since 2005 has greatly improved the ability of children to receive this treatment.

In school year 2003-2004, the IDPH Division of Oral Health (DOH) completed a basic screening survey of third-grade children. The Healthy Smiles/Healthy Growth survey obtained important information about caries history (whether or not a child had evidence of any prior cavities), current untreated cavities, treatment urgency, presence of sealants, demographics, and socioeconomic variables. That survey found that 27 percent of all third-graders had at least one dental sealant.

This performance measure is addressed by the IDPH Dental Sealant Grant Program. Retention rates, monthly and quarterly reports, and on-site reviews are utilized to evaluate program performance. Communities are responsible for developing protocols for their programs in order to assure proper infection control, retention rates, equipment maintenance, patient referral and follow-up and adequate procedures for assuring eligibility.

The IDPH Dental Sealant Grant Program completed an evaluation of the sealant program based on CDC's Program Evaluation Guide. The evaluation documented achievement of programmatic objectives, accomplishment of planned activities, and the quality of care provided through the program. Based on the evaluation of the program's data needs and collection process, the DOH offers sealant program software to community programs. DOH trained 12 grantee communities to electronically collect data that provides program management and evaluation, including an assessment of program cost effectiveness and averted disease rates. The community programs provided school dental examinations as an adjunct to the program in order to assure their schools

and the children they serve are compliant with the new school dental examination statute in Illinois. The mandate requires all children in kindergarten, second, and sixth grades to show proof of a dental examination. The first three years of data (2005-2008) demonstrated excellent compliance rates. In 2007, schools began to report oral health status information that may prove to be a valuable source of community specific data.

The IFLOSS Oral Health Coalition has had a working group since 2009 that is investigating the dental health needs for children with special health care needs. Also, oral health staff have established a working relationship with staff from the IDPH Office of Health Promotion's Disabilites Program, funded by the CDC.

Chicago. 2008 -- 2009 School Year. The Chicago Department of Public Health School-Based Oral Health Program is on target to perform oral health services for approximately 90,000 children and place approximately 210,000 dental sealants. Services will be provided in approximately 583 schools during the 2009-2010 academic years. The Program is still using the scannable dental record program. Walk out letters and Illinois Department of Public Health Oral Health reporting forms were provided to all participating students.

Approximately 12,000 students presented with dental caries and received a dental referral. Approximately 3,500 presented with urgent dental caries and received a dental referral.

The School-Based Oral Health Program participated again in the 2008-2009 Basic Screening survey entitled Healthy Smiles/Healthy Growth. The data for Chicago showed an increase in dental caries from 59 percent to 63.5 percent in the past five years (2003-2004 results), and an increase in students with sealant(s) from 12 percent to 34.3 percent in the same time period.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. IDPH works with local health departments and schools to conduct dental sealant grant programs.	X			
2. IDHFS contracts with Doral Dental to monitor sealant levels and conduct targeted outreach.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

IDPH has 60 dental sealant program grantees throughout the state that provide oral health care, oral health education, dental examinations, referrals for needed treatment, and outreach for All Kids enrollment. The IDPH DOH is providing technical assistance and training on a new dental sealant data system, Sealant Efficiency Assessment for Locals and States (SEALs) for 12 community programs. The data system monitors their program performance and provides monthly reports to the DOH electronically, easing the amount of paperwork involved in the program. SEALS will be a source of oral health status data as it collects Decayed Missing Filled Teeth Surfaces information on every participating child.

The DOH is working with the IDHFS to enhance the sealant program referral process using the Medicaid administrator, Doral of Illinois, to contact families with children identified through the sealant program as needing dental treatment.

Chicago. The Chicago Department of Public Health School-based Dental Sealant Program Quality Assurance Program continues to review the work of oral health care providers. The sealant retention rate was well over the 90 percent required by the State. The Chicago program has installed a data system using scannable forms that will aid their reporting process to IDPH, the Chicago Public School System and the Illinois State Board of Education.

c. Plan for the Coming Year

The DOH will continue to evaluate the use of the CDC's SEALs reporting software and to collect electronic data from additional grantees using other dental program data systems, such as Dentrix. The program will continue to work with IDHFS to monitor and assure case management and referral and the quality of oral health care provided in school-based programs.

Chicago. The Dental Sealant Program is planning to implement an electronic data collection program and the SEALS Program is included in the discussion.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.4	2.4	2.4	2	1.9
Annual Indicator	2.0	2.2	2.1	2.1	2.1
Numerator	55	58	54		
Denominator	2752100	2640114	2631525		
Data Source				IDPH- Vital Records	IDPH - Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1.9	1.8	1.8	1.8	1.8

Notes - 2009

Vital Records data for deaths for 2009 are not available at this time.

Notes - 2008

Vital Records data for deaths for 2008 are not available at this time.

Notes - 2007

Source: IDPH Vital Records for numerator and Census estimates for denominator.

a. Last Year's Accomplishments
For calendar year 2007, the last year for which death data was available from IDPH for the state, Illinois achieved its goal of reducing the rate of motor vehicle crash deaths among children between one and 14 years of age to 2.4 per 100,000 children. Actual performance was 2.1 per 100,000 in 2007.

IDPH continued its partnership with the Chicago Police Department, the Illinois State Police, local hospitals and health centers, and the IDCFS to conduct community child safety seat checks. Through this partnership, 45 safety seat checks were held, and 1,400 car safety seats were distributed to low-income families, and more than 3,000 car seats were checked for proper seat installation. During a car seat check clients are shown how to properly use seat belts as well as proper car seat installation.

Children with special health care needs are referred to LaRabida Hospital for services.

Chicago. In Chicago in 2007, eleven children aged 14 years and younger died in motor vehicle accidents. This calculates at 2.5 per 100,000 children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS participates in child safety seat checks and seat distribution.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The IDPH Safe Kids Illinois program was transferred in 2009 to Children's Memorial Hospital in Chicago. The CDPH no longer distributes car seats; however, when they are available, staff encourage clients to attend the educational sessions and to receive a car seat.

c. Plan for the Coming Year
Child safety seat checks and distribution of child safety seats will be handled by the Illinois State Police, Illinois Department of Transportation, a network of health departments, community-based organizations, DHS local offices, churches and Children's Memorial Hospital. Use of child safety seats is a community issue.

Many parents cannot afford to purchase a child safety seat and/or do not know how to properly install the safety seat. The Child Passenger Protection Act was established to protect the health and safety of children through the proper use of an approved child safety restraint system.

Healthy Child Care Illinois provides families and child care providers with educational support and resource referrals on transportation safety to include the importance of child safety seats.

All students enrolled in school health centers are assessed for risk of unintentional injury and provided with health education focused on injury prevention, bicycle safety, and seat belt use.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		31	28	26	27
Annual Indicator	30.0	28.0	25.7	25.7	27.3
Numerator	16187	15328	14483	15193	16874
Denominator	53960	54663	56315	59219	61786
Data Source				IDHS, WIC Program	IDHS, WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	27	28	28	28	29

Notes - 2009
The Numerator is infants Still Breastfed at 6 Months. The Denominator is infants Ever Breastfed. Source: Count and Percent of WIC Breastfed Infants, SFY 2009 Annual Report, CHP, IDHS.

Notes - 2008
The Numerator is infants Still Breastfed at 6 Months. The Denominator is infants Ever Breastfed. Source: Count and Percent of WIC Breastfed Infants, SFY 2008 Annual Report, CHP, IDHS. According to the Breastfeeding Report Card, United States 2008: Outcome Indicators (which reports WIC and Other data) the Illinois' percent at 'breastfed at 6 months' was 37.5.

The downward trend is due to stricter edits or quality assurances measures added to the client information system. Previously, WIC service providers reported breast feeding at the first assessment (newborn) and did not update that information upon subsequent visits. The information system now requires an update with every certification/assessment visit. The reported information more accurately reflects breast feeding behavior at six months than in previous years.

Notes - 2007
The Numerator is infants Still Breastfed at 6 Months. The Denominator is infants Ever Breastfed. Source: Count and Percent of WIC Breastfed Infants, SFY 2007 Annual Report, CHP, IDHS. According to the Breastfeeding Report Card, United States 2007: Outcome Indicators (which reports WIC and Other data) the Illinois' percent at 'breastfed at 6 months' was 40.9.

The downward trend is due to stricter edits or quality assurances measures added to the client information system. Previously, WIC service providers reported breast feeding at the first assessment (newborn) and did not update that information upon subsequent visits. The information system now requires an update with every certification/assessment visit. The

reported information more accurately reflects breast feeding behavior at six months than in previous years.

a. Last Year's Accomplishments
In 2009, 27.3 percent of WIC participants continued breastfeeding for six months. From the 2009 CDC Breastfeeding Report Card, United States -- 2009: Outcome Indicators, all Illinois women had a 38.7 percent breastfeeding rate at six months. Illinois collects data on breastfeeding practices through the Cornerstone Information System for CDC's Nutrition Surveillance Systems and internal and external use in identifying breastfeeding patterns and practices. These include: initiation and duration of breastfeeding, exclusivity, client contacts, and breast pump issuance.

To promote and support extended breastfeeding among the WIC population, IDHS has provided technical assistance and consultation on breastfeeding promotion, support and management for health departments and other local agencies administering WIC and other MCH programs statewide. Through regional and statewide training, staff are kept up to date with advances in breastfeeding research. Events included a two-day State Breastfeeding Conference; week-long intensive breastfeeding trainings that resulted in certification as a Certified Lactation Counselor, Certified Lactation Specialist, or Breastfeeding Support Counselor; and two "Bridges to Breastfeeding" workshops.

IDHS collaborates with IDPH Division of Chronic Disease Prevention & Control to develop strategies to increase awareness of breastfeeding's role in preventing obesity. The "Grandmother's Tea Project," a collaborative effort with IDPH, has been implemented regionally throughout Illinois. Presented as a tea, breakfast or group education, the concept can be adapted to any group and used to help family members learn about the important role they play in supporting breastfeeding mothers.

Staff are trained to provide breastfeeding support and assistance to all mothers and babies, including CSHCN. Trainings and conferences provide opportunities to learn strategies and problem-solve special situations, e.g. babies with Down Syndrome, cleft palate, etc. Staff is encouraged to provide hands-on assistance to overcome special challenges in breastfeeding dyads

Chicago/local agencies: CDPH continues to actively promote breast feeding activities in the City. In 2009, the agency held the 4th annual "Breastfeeding Promotion Walk and Celebration Day" at Rainbow Park and Beach. Over 800 participants, including men, women, grandparents, children and infants from all racial and ethnic groups attended and rallied their support for breastfeeding. Numerous breastfeeding and child health advocacy organizations participated with CDPH and helped make this event successful. They included: Healthy Families of Illinois; March of Dimes; SIDs of Illinois; Chicago Breastfeeding Task Force; LaLeche League; Ameda and Medela. Vendors and supporters provided live entertainment, lunch, healthy snacks, and take home items that included breastfeeding literature, tee shirts, book bags, school supplies and raffle gifts.

Faith-Based Organizations: In 2009, CDPH and St Bernard's Hospital sponsored a luncheon for the First Ladies from a number of churches. CDPH provided them with materials on breast feeding for the pastors to include in their sermons and wellness programs. The State modified the church packages for use by Illinois WIC Programs.

Hospital Collaboration: The Rush Presbyterian Hospital Neonatal Intensive Care Unit staff received funds and launched the Griffin Inaugural Conference (named after its sponsor) in August 2009. This funding is designed to increase breast feeding among low income Chicago women. Rush Hospital and Chicago area WIC agencies collaborated to develop the DVD "In your Hands" to emphasize breast milk as the only food for premature and low-birth weight infants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS promotes breastfeeding through the WIC program.		X		
2. IDHS provides technical assistance and consultation on breastfeeding promotion for local WIC providers.				X
3. IDHS increases the grant awards of local WIC agencies that excel in breastfeeding initiation and duration.				X
4. IDHS distributes promotional items for World Breastfeeding Week and Illinois Breastfeeding Month.				X
5. IDHS conducts training programs for breastfeeding coordinators in local WIC programs.				X
6. IDHS supports the activities of state and regional breastfeeding task forces.				X
7. IDHS oversees a breast pump program.		X		
8. IDHS provides breastfeeding education to the local staff of other MCH programs.		X		
9. IDHS collects information for CDC's Prenatal and Pediatric Nutrition Surveillance Systems through Cornerstone.				X
10. IDHS is taking the lead in drafting a "Breastfeeding Blueprint for Illinois"		X		

b. Current Activities

Illinois Breastfeeding Promotion and Support Month will be celebrated in August, coinciding with International World Breastfeeding Week. IDHS continues to support the activities of local agency Breastfeeding Coordinators statewide through technical assistance and educational materials. Breastfeeding program updates are provided on a regular basis through regional meetings and a bi-monthly newsletter.

IDHS provides technical assistance to local agencies with Peer Counselor programs and other breastfeeding projects. Forty-five agencies and over 75 Peer Counselors provide services to eligible participants. The first Annual Peer Counselor Conference and Celebration provided breastfeeding training and updates to over 130 Peer Counselors and Peer Counselor Supervisors.

Training of staff and community partners continues to be a priority. Besides trainings focused on MCH program staff, regional task forces present breastfeeding conferences with nationally known speakers to help promote community awareness and education for members of their community.

Chicago. CDPH continues to lead a citywide celebration in recognition of the importance of breastfeeding for the health of Chicago's children. The 5th annual Breastfeeding Awareness Walk and Celebration will be held in August 2010. All WIC sites have a designated breast-feeding room, furnished and decorated in a comfortable and welcoming manner.

c. Plan for the Coming Year

Illinois Breastfeeding Promotion and Support Month will be celebrated in August, coinciding with International World Breastfeeding Week. IDHS continues to support the activities of local agency Breastfeeding Coordinators statewide through technical assistance and educational materials. Breastfeeding program updates are provided on a regular basis through regional meetings and a bi-monthly newsletter.

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Chicago. CDPH continues to lead a citywide celebration in recognition of the importance of breastfeeding for the health of Chicago's children. The 5th annual Breastfeeding Awareness Walk and Celebration will be held in August 2010. All WIC sites have a designated breast-feeding room, furnished and decorated in a comfortable and welcoming manner.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	96	97	99	99.2	99.2
Annual Indicator	96.2	98.6	96.9	96.6	98.9
Numerator	169068	170271	174909	170629	165415
Denominator	175659	172602	180530	176634	167192
Data Source				IDPH, Vision & Hearing	IDPH, Vision and Hearing
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	97	97.2	97.4	97.6	98

Notes - 2009
Source: IDPH Vision and Hearing Screening Program, April 2010.

Notes - 2008
Source: IDPH Vision and Hearing Screening Program, April 2009.

Notes - 2007
Source: IDPH Vision and Hearing Screening Program, 2008.

a. Last Year's Accomplishments
Provisional 2009 data from the IDPH Early Hearing Detection and Intervention (EHDI) program reveals 167,192 births for the state. Of those reported 98.9 percent of the infants were screened prior to discharge. The referral rate was 3.6 percent for these infants. To date, 183 infants born in 2009 have a confirmed hearing loss. Provisional 2008 data from Illinois vital records reveals 176,634 births for the state. A total of 172,317 infant results were reported to the EHDI program.

This indicates 96.6 percent of the infants and newborn hearing screening results were reported to the program. Of the infants reported to the EHDI program, 99.2 percent were screened prior to discharge. Of those screened, less than four percent were referred prior to discharge and only 0.04 percent were not screened prior to discharge. For infants born in 2008, 242 were identified with permanent hearing loss. This suggests an incidence rate of 1.4/1,000 for infants receiving a newborn hearing screening at birth. The average age in months of identification of bilateral hearing loss was 5.1 months. Of the infants with confirmed permanent hearing loss, 49 percent are confirmed to have enrolled in Part C services. Illinois is the fifth largest birthing state in the nation and has diverse demographics across the large state. However, the 2008 data is exemplary compared to national statistics.

The EHDI program is a shared initiative of three different state agencies in Illinois: Illinois Department of Public Health (IDPH), the Division of Specialized Care for Children (DSCC) which is the Title V Children with Special Health Care Needs Program and the Illinois Department of Human Services, which administers the federal Early Intervention (Part C) program. Only aggregate data can be shared unless the parents sign an authorization to release their child's data among the agencies. The EHDI tracking system does not link to either birth certificates or metabolic screening data.

Beginning April 1, 2008, DSCC was the recipient of a three year HRSA Early Hearing Detection and Intervention (EHDI) grant. The grant's focus was to Reduce Loss to Follow-up in the state. The grant funded support for the EHDI coordinator position at DSCC to oversee EHDI operations, including public awareness activities, parent outreach, and stakeholder training at all levels from screening to diagnosis and through intervention.

With the goal of reducing loss to follow-up, Illinois initiated a quality improvement (QI) learning collaborative. The grant funded quality improvement activities that used the Plan-Do-Study-Act (PDSA) model focused on strengthening links between screening, diagnosis, reporting, referral to EI and connection to a Medical Home. In the first year of the project, four metropolitan birthing hospital systems participated. Three of the four institutions had audiology diagnostic services within the health system. Nursery staff, administrators, audiologists, social workers, early interventionists and parents comprised the 30 to 40 members of the collaborative. Three onsite learning sessions were completed. The learning sessions were supported by conference calls and email exchanges. Message scripting, "2nd point of contact" and linking to a medical home were key change concepts tested and implemented during the year. Members were trained on the Early Intervention system, CSHCN program, IDPH data tracking, relating to deaf culture and communication access for all.

In addition, the EHDI coordinator at DSCC assisted in providing technical assistance to hospitals, audiologists, physicians and interventionists; facilitated linkages to the Part C and CSHCN Programs (so that infants were enrolled before reaching six months of age) as well as linkages to parent to parent support and medical home services; encouraged new audiology providers to participate in the state Medicaid and Part C Programs; maintained the parent friendly, ADA-compliant website, www.illinoissoundbeginnings.org; and worked with the newborn hearing advisory committee. DSCC, through the Follow Up grant, was also one of the founding partners to bring Guide By Your Side (GBYS), a discipline-specific parent-to-parent support program, to the state.

Chicago: The Chicago Department of Public Health's Nursing staff visit parents to ensure that infants return for their follow-up visits.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Hospital screens each newborn for hearing loss.			X	
2. Test results reported to IDPH.				X
3. Parents and physicians are notified of abnormal test results and informed of diagnostic testing procedures.			X	
4. Diagnostic testing is performed by audiologists.	X			
5. Confirmed diagnoses are reported to IDPH.				X
6. Children with diagnosed hearing loss are referred to the Early Intevention and CSHCN programs.		X		
7. DSCC pays for diagnostic evaluation for families who cannot afford it or have insurance that does not cover it.	X			
8. IDHS convenes the Hearing Screening Advisory Committee and monitors program operation.				X
9.				
10.				

b. Current Activities

Illinois was awarded supplemental funding that goes through March 31, 2011. Illinois continues to address challenges related to infants lost to follow-up from screening through intervention. Activities support the use of PDSA Quality Improvement activities using the model developed by NICHQ.

Illinois is participating in the NICHQ collaborative as well as conducting a state collaborative. National members represented: Title V, parents, audiologists, nursery staff, and early interventionists. The national team traveled to three on-site trainings, participated in webinars, teleconferences and other internet based learning. Illinois is implementing the knowledge gained from the national collaborative in the state level learning collaboratives.

Both the national and state collaboratives focus on strengthening the links between screening, diagnosis, reporting, referral to EI and GBYS, and connecting to a Medical Home. At the state level, three community teams in central, more rural, Illinois represent birthing hospitals with or without follow-up services as part of the hospital network.

Also, a parent workgroup was established in tandem with the learning collaborative to develop parent-friendly state EHDI materials and local hospital materials. Each item is subject to the quality improvement development process. DSCC continues to use grant funds to support the coordinator to oversee program operations, awareness activities, and training of stakeholders.

c. Plan for the Coming Year

The final year of HRSA grant ends March 31, 2011. Illinois' will continue to address challenges related to infants lost to follow-up from screening through intervention using the quality improvement model.

DSCC will continue to use EHDI grant funds to support the coordinator to oversee daily program operations,. Parent resources will continue to be provided at no charge to families. DSCC will continue to support IDPH in providing technical assistance to hospitals, audiologists, physicians and interventionists; facilitate linkages to the Part C and CSHCN parent-to-parent support and medical homes ; encourage new audiology providers to participate in the state Medicaid and Part C Programs; and work with the newborn hearing advisory committee.

DSCC will coordinate the third QI learning collaborative, which will be in the northern, more populated, part of the state. The QI activities will use the PDSA model. Information and experience obtained through participating in the NICHQ learning collaborative will be utilized. Over 40 change concepts that cover all stages in the EHDI process and lead to the reduction in

loss to follow-up between screening and intervention will be shared with community teams. All tests of change will focus on strengthening links between screening, diagnosis, reporting, referral to EI and connection to a Medical Home while using outcome measures to verify benefit. Nursery staff, administrators, audiologists, social workers, early interventionists physicians and parents/consumers will be encouraged to participate. Three on-site learning sessions will be completed. The learning sessions will be supported by conference calls, webinars, list-serves, surveys and email exchanges.

Highlights of activities that are possible due to the supplemental grant funding include: redesign of the parent-friendly, ADA-compliant website, www.illinoissoundbeginnings.org, to a dynamic resource for all EHDI stakeholders; support of the GBYS Program outreach with a focus on the Latino community in the state; development of a parent resource manual; partnering to develop a professional video for parents to encourage follow-up after not passing newborn hearing screening; collaboration to provide newborn hearing screening training and outcome measures for all birthing hospitals; and collaboration to provide increased access to diagnostic follow-up for newborns who do not pass the hearing screening in the hospital.

Chicago. CDPH will develop and implement a tracking system for all EHDI referrals from IDPH.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.7	6.6	5.9	5.9	4.1
Annual Indicator	6.0	5.9	4.1	5.1	5.1
Numerator	204000	198000	138000	170000	
Denominator	3424000	3339000	3366000	3331000	
Data Source				Census Bureau, Current Population Survey	Census Bureau, Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4	4	3.9	3.9	3.8

Notes - 2009

The final 2009 income data will be available when the Current Population Survey 2009 Annual Social and Economic Supplement will be released. It is expected in September 2010.

Notes - 2008
Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement. Table HI10. Number and percent of children under 19 at or below 200% of poverty by health insurance coverage and state: 2008.

Notes - 2007
Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement. Table HI10. Number and percent of children under 19 at or below 200% of poverty by health insurance coverage and state: 2007.

a. Last Year's Accomplishments
In an effort to enroll uninsured children into the IDHFS' medical program for health care coverage, IDHFS has partnered with the Illinois Maternal and Child Health Coalition (IMCHC) since 2007 to conduct outreach and education to raise awareness of health insurance, health care services, improved health outcomes with health benefits coverage, health benefits coverage under IDHFS' medical programs, the importance of health insurance and identification of available health insurance and the need for appropriate health care utilization.

IDHFS partners with over approximately 900 community organizations, medical providers, and insurance agents who are trained as All Kids Application Agents to help enroll families throughout the state in All Kids and FamilyCare. All Kids, an affordable, comprehensive health insurance plan for all uninsured Illinois children age 18 or younger, was signed into law on November 15, 2005. The plan went into effect on July 1, 2006. It pays for doctor visits, hospitalizations, dental care, vision care, prescription medications, medical equipment, and mental health services. The monthly premiums and co-pays are based on the family's income. IDHFS mails information about All Kids to FCM and WIC recipients each annually.

Chicago. The Office of Health Care Access (OHCA) provides information and advocacy to consumers on Medicaid and Medicare eligibility, public health entitlement programs, and on private insurance options. In CY2007, OHCA developed and distributed nearly 459,000 maternal and child health-related printed publications to consumers and partners. All publications are printed in English and Spanish; publications in other languages are printed as needed. OHCA provides application assistance to state and federal programs for families through the CAREline call center and in neighborhood health and mental health centers. The OHCA CAREline answered over 1,400 calls from community residents having difficulty with their public health care plans. OHCA is the CDPH liaison for Illinois Health Connect, the state's primary care case management program, and for Your Healthcare Plus, the state's disease management program In CY'09, the CDPH completed more than 1.860 All Kids applications. All Kids administration now resides in OHCA.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. IDHS grantees assist families in applying for All Kids and FamilyCare.		X		
2. DSCC requires eligible families to apply for All Kids.		X		
3. IDHFS covers uninsured children through All Kids.		X		
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
Of children enrolled in WIC in early 2010, 96 percent had All Kids or other insurance coverage. FCM providers are required to document giving parent information regarding Illinois' All Kids program and information on how to enroll. This information is recorded in Cornerstone and quarterly performance reports are issued to track compliance. Most FCM providers are All Kids agents, which allows them to assist clients in completing applications on-site. Healthy Start and Targeted Intensive Prenatal Service providers also are required to disseminate information concerning All Kids coverage to new clients at time of program enrollment.

Chicago. Through its OHCA, clinics, home visiting programs, collaboration with other organizations and health fairs, CDPH staff continues to increase its emphasis on educating families and enrolling eligible individuals in All Kids and FamilyCare, and pregnant women in Moms & Babies and Medicaid Presumptive Eligibility (MPE.)

c. Plan for the Coming Year
IDHS and IDHFS will continue to promote enrollment in All Kids to reduce the proportion of children without health insurance. IDHS will use the Cornerstone system to monitor the number of WIC/FCM eligible children who do not have insurance coverage. These children will be targeted by local WIC and Family Case Management grantees for additional outreach efforts to encourage their parents to enroll them in All Kids. IDHFS will continue to provide training and field staff support to All Kids Application Agents (AKAAs). SHCs will determine insurance status of all enrolled students and refer those without insurance to All Kids.
In addition, the Healthy Child Care Illinois Program Child Care Nurse Consultants provide All Kids enrollment information to all of Illinois' child care providers and families who attend outreach education programs.

IDPH requires Dental Sealant programs to educate and enroll families in All Kids.

Chicago. CDPH staff will continue to increase its emphasis on enrolling eligible individuals in various state-sponsored health insurance programs including Medicaid, All Kids, FamilyCare, Moms & Babies, and Medicaid Presumptive Eligibility. Enrollments will be done by FCM, PHN, Immunization Program, and the clinics, as well as staff from the OHCA. The OHCA will continue to provide education for both providers and the community, and will continue to operate the CAREline.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		24	23	29.9	29.8
Annual Indicator	24.2	29.8	29.9	30.3	30.2
Numerator	19718		109549	121608	133023
Denominator	81616		366250	401000	440000
Data Source				PedNSS	PedNSS
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29.5	29	28.5	28.5	28.5

Notes - 2009
Source: Table 2C-Summary of Health Indicators, Children Aged <5 Years, Illinois 2009, CDC's Pediatric Nutrition Surveillance System (PedNSS). 2009 numerator: PedNSS state data; denominator: estimated to make published rate. Report date: 6/9/2010.

Notes - 2008
Source: Table 2C-Summary of Health Indicators, Children Aged <5 Years, Illinois 2008, CDC's Pediatric Nutrition Surveillance System (PedNSS). 2008 numerator: PedNSS state data; denominator: estimated to make published rate. CDC issued revised 2008 report as of 6/9/2010 with more clients counted.

Notes - 2007
Source: Table 2C-Summary of Health Indicators, Children Aged <5 Years, Illinois 2007, CDC's Pediatric Nutrition Surveillance System (PedNSS). 2007 numerator: PedNSS state data; denominator: estimated to make published rate.

a. Last Year's Accomplishments
In 2008, 30.0 percent of children between 2 and 5 years of age who received WIC services had a BMI score at or above the 85 percentile. Illinois is following the national trend in the epidemic of overweight/obesity. The prevalence of overweight in children (2-5 years of age) in Illinois has gradually increased from 9.3 percent in 1976 to 15.3 percent in 2008. An additional 14.7 percent of children in the same age group are considered "at-risk" for being overweight. The national average for overweight is 16.4 percent and at-risk is 14.9 percent (Pediatric Nutrition Surveillance System 2008).

IDHS is in a unique position to impact childhood obesity. Within IDHS, the WIC Program is able to educate mothers during their pregnancy about weight gain, healthful eating and breastfeeding. Breastfeeding and early eating habits are important and nearly 50 percent of infants born in Illinois participate in the WIC Program, thus receiving prevention messages from the start. Routine contacts with WIC continue throughout the 4th year of life.

Training events in 2009 focused on implementing the new WIC food packages. The new packages align with the Dietary Guidelines for Americans providing reduced fat milk for all participants over age 2, reducing cheese and juice quantities, adding whole grains and providing fresh, frozen or canned fruits and vegetables each month. Staff were educated over the course of the year with the new packages being released in August. Regional workshops were held in March with University of Illinois Extension staff, so both WIC and Extension nutrition educators would understand the rationale behind the changes and how to educate participants on making healthy meals with the new food items. Luncheons were held using WIC foods in most regions.

Staff is trained to provide nutrition education and counseling relevant to the needs of each individual. Children with special health care needs may now receive foods items as well as specialized formulas based on physician recommendations with the goal of providing as normal diet possible to WIC's medically fragile population.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train IDHS BFN Nutrition Staff on obesity prevention and intervention strategies.				X
2. Train local WIC Providers on obesity prevention and intervention strategies.	X			
3. Collaborate with community partners such as CLOCC and the Illinois Interagency Nutrition Council to create common messages and maximize resources.		X		
4. Provide nutritious foods through the WIC, CSFP and WIC Farmer's Market Nutrition Programs.	X	X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In addition to promoting/supporting breastfeeding, encouraging families to consume healthy foods and be active every day, the WIC Program partners with the University of Illinois Extension to provide "Cooking School" Programs. This project will continue in 2010. Students learn the basics of cooking using WIC foods. A downstate pilot was held in Springfield. Six on-site classes were held at a women's shelter. There were significant logistical barriers and it is unclear if the program will be offered in the future. IDHS staff remains involved with the Consortium to Lower Obesity in Chicago Children (CLOCC). Bureau of Family Nutrition staff participates in the following workgroups: Early Childhood, Health Communities, and Government Policy. The Bureau is listed in the CLOCC Program database which can be found on the website www.clocc.net. WIC staff provided public comments at the IDPH public hearings on childhood obesity in 2010.

In 2009 the Illinois WIC Farmers Market Nutrition Program was provided in 34 counties. Two additional sites will be added in 2010.

c. Plan for the Coming Year

The Southern Illinois Healthy Child Task Force has been funded for SFY2011 to continue their efforts to prevent and address childhood obesity in southern Illinois. The group continues to meet regularly with good attendance and sharing of information and grant opportunities. A conference is being planned in 2010.

In October 2010 new WIC eligibility risk factors will be introduced which are focused on maternal weight gain, diabetes, prediabetes and gestational diabetes. Local staff will receive training on assessment and counseling related to these risks which should further the discussion on the prevention of childhood obesity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Performance Objective		12.4	12.2	10	11
Annual Indicator	12.6	12.1	10.4	11.4	10.7
Numerator	23000		17586	19380	18304
Denominator	182393		169356	169854	171023
Data Source				IDPH, PRAMS	IDPH, PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	10	10	10	10

Notes - 2009
Source: 2007 PRAMS, Illinois Department of Public Health (IDPH). 2008 PRAMS data were not available for this application from IDPH.

The objectives for 2008-2012 have been adjusted to account for the decline of women who smoke in the last trimester as reported in the 2004 and 2005 PRAMS.

Notes - 2008
Source: 2006 PRAMS, Illinois Department of Public Health (IDPH). 2007 PRAMS data were not available for this application from IDPH.

The objectives for 2008-2012 have been adjusted to account for the decline of women who smoke in the last trimester as reported in the 2004 and 2005 PRAMS.

Notes - 2007
Source: 2005 PRAMS, Illinois Department of Public Health (IDPH).

The objectives for 2008-2012 have been adjusted to account for the decline of women who smoke in the last trimester as reported in the 2004 and 2005 PRAMS.

a. Last Year's Accomplishments
As of 2008, 11.4 percent of women reported smoking in the last trimester of their pregnancy. Non-Hispanic women, as well as black and white women were more likely to smoke during all three time periods when compared to Hispanic women and women of all other races. Women with less than a high school education reported smoking more often during all time periods when compared to women with more than a high school education. Unmarried women and women whose deliveries were paid for by Medicaid reported much higher rates of smoking during all three time periods when compared to married women and women whose deliveries were not paid for by Medicaid.

IDHS, IDPH, and IDHFS use a coordinated strategy to reduce smoking among women who are participating in WIC, FCM, and other MCH programs. It has three components: implementation of the "Five A's;" use of the Illinois Tobacco QuitLine; and reimbursement of smoking cessation medications through the Medicaid Program. MCH program staff were encouraged to enhance their current procedures by implementing the recommendations of the American College of Obstetricians and Gynecologists (ACOG). Their recommendations include the following steps, often referred to as "the five A's": Ask about tobacco use; Advise women to quit; Assess willingness to make a quit attempt; Assist in the quit attempt; and Arrange follow-up.

Pregnant or parenting women who are smoking may be referred to the American Lung Association QuitLine for ongoing assistance. The Illinois Tobacco QuitLine was developed by IDPH and the American Lung Association, and is supported by Tobacco Settlement Funds. The QuitLine offers free, confidential counseling to smokers related to all stages of the quitting process, including nutrition and weight management, information about cessation medications, and management skills for dealing with withdrawal symptoms. QuitLine Staff will make appointments with callers for follow-up and provide on-going support through the process of quitting. All callers, regardless of income, are eligible to receive counseling services. QuitLine hours are 7:00 AM to 7:00 PM (CT), Monday through Friday. Bilingual services are available. The QuitLine is staffed by registered nurses and respiratory therapists who have been trained at the Mayo Clinic.

Enrolled pharmacies may bill the IDHFS Medicaid program on behalf of eligible women for certain medications and over-the-counter items to assist them in quitting the use of tobacco. IDHFS covers both prescription and over-the-counter smoking cessation products when obtained with a prescription.

Chicago. CDPH's Women's Maternal Smoking Intervention program operates in WIC sites and CDPH Clinics. In 2009, the program provided services to 312 women, eight percent less than in 2008. There were 143 women who were pregnant, of which 97 (68 percent) agreed to quit smoking, and 30 (21 percent) who cut down on their smoking. Also, 81 percent of all program women stopped smoking in the presence of their children. The Women's/Maternal Smoking Intervention program continued incorporating the NicAlert nicotine exposure screening to demonstrate exposure to secondhand smoke with a partnership with the Infant Mortality Reduction Initiative-South, motivating more women to report their smoking and smoking of others in their homes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implementation of the “Five A’s” in MCH programs.		X		
2. Promote the Illinois Tobacco QuitLine.			X	
3. The Medicaid program reimburses the cost of smoking cessation medications.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

An on-line training module will be available to WIC and other IDHS health professionals via the Community Health Training Center. The module focuses on high-risk WIC participants. A portion of the module addresses the risks of smoking during pregnancy and the "Five A's" of smoking cessation.

Each Illinois WIC participant is required to receive education on the dangers of drugs, alcohol and tobacco. Key messages are displayed at local WIC offices via posters and brochures and are discussed during regular visits. Key messages are highlighted on the back of the Illinois WIC Food List which is given to every participant.

Chicago. The Women's/Maternal Smoking Intervention Program is continuing to provide and support health care providers with materials to offer their clients who are assessed as being smokers. Providers are encouraged to refer clients to the Illinois Tobacco-Free Communities (ITFC) representative for assistance in quitting through telephone counseling. A free smoking cessation workshop (Courage to Quit) is offered with free nicotine replacement therapy provided by ITFC when available. The ITFC representative also recommends that they use the Illinois Tobacco Quit-line.

c. Plan for the Coming Year

The IDHS, IDPH, and IDHFS will continue the initiative to reduce smoking among women who are participating in WIC, FCM, and other Maternal and Child Health programs. Pregnant or parenting women who are smoking will be referred to the American Lung Association's QuitLine for ongoing assistance. Agencies will use a smoking cessation curriculum, "Make Yours A Fresh Start Family," to help clients quit or decrease their smoking. Materials will be available, at no charge, for use in promoting the QuitLine and the importance of smoking cessation to women who are participating in the WIC and FCM programs. Information on the smoking status of participants will be monitored through the Cornerstone System, and client progress available to providers on a quarterly basis. Additionally, IDHFS will be implementing several smoking cessation training initiatives in the next year to pilot evidence-based practices and evaluate results.

Chicago. The Women's/Maternal Smoking Intervention program will continue its NicAlert nicotine exposure screenings, with the assistance of the public health nurses. In addition, there will be outreach to other CDPH programs that reach women or are family-oriented.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.4	4.7	6	6	5
Annual Indicator	5.5	5.1	6.5	6.5	6.5
Numerator	50	48	61		
Denominator	916148	939462	936963		
Data Source				IDPH, Center for Health Statistics	IDPH, Center for Health Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	5	5	5	5

Notes - 2009
Vital Records data for deaths in 2008 or 2009 are not available at this time.

Notes - 2008
Vital Records data for deaths in 2008 or 2009 are not available at this time.

Notes - 2007
Source: IDPH, Vital Records for numerator and Census population estimates for denominator.

a. Last Year's Accomplishments
All 40 School Health Centers provide mental health counseling on-site or have agreements with outside community providers for individual, group, or inpatient care as needed. The mental health committee within the Coalition for School Health Centers developed and distributed to the centers a document entitled "Suicide Assessment and Management: Guidelines for Illinois School Based Health Centers." Training was provided via satellite to DCHP staff and contractors on signs, causes, and referral procedures on adolescent suicide.

Below are highlights of the IDPH's suicide prevention activities. The Illinois Suicide Prevention Strategic Plan was officially released through the IDPH. A total of $350,000 was appropriated by the Illinois General Assembly in FY08 to fund suicide prevention. IDPH contracted with the Mental Health America of Illinois (MHAI) to implement activities during FY09. The contract included development of a public awareness campaign; building local coalitions; providing data analysis; and training providers in the field of aging, education and human services, in addition to including an evaluation component. In 2009, IDPH awarded a grant to Children's Memorial Hospital, Children's Data Lab to continue to implement the Illinois Violent Death Reporting System in three counties. More than half of the violent deaths in the system are suicides. IDPH provided funds to the Farm Resource Center to offer outreach crisis intervention in the 38 southernmost counties of the state. IDPH collaborated with the Pacific Institute for Research and Evaluation to update the Illinois data fact sheet sponsored by the Suicide Prevention Resource Center. IDPH provided technical assistance to state and local entities as well as conducted presentations and displays.

The Illinois Suicide Prevention Alliance serves as the advisory board to the IDPH. The members are appointed by the Director of Public Health.

Currently, there are no injury or suicide prevention activities focused on CSHCN.

Chicago. The Chicago Public Schools receive funding from CDC to monitor critical health behaviors in youth through implementation of the Youth Risk Behavior Survey (YRBS.) Data are collected on a biannual basis. In 2007, 13.4 percent of students had seriously considered attempting suicide during the 12 month period before the survey, and 10.1 percent had made a plan. This was higher than the 2005 percentage of 12.9. percent who had considered suicide and approximately equal to the 10.6 percent who had made a plan. In Chicago in 2007, 10 (5.3/100,000) youth committed suicide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The School Health Centers provide mental health counseling.	X			
2. Mental health counseling services are available on-site from two Teen Parent Services program offices.	X			
3. IDHS provides training on the risk factors for adolescent suicide.				X

4. IDHS distributes information on teen suicide through the school health program.				X
5. IDHS participates in the Illinois Suicide Prevention Alliance.				X
6. IDPH will ensure that prevention programs serve as school gatekeepers and provide faculty training.				X
7. IDPH will ensure that prevention programs conduct community gatekeeper training.				X
8. IDPH will ensure that prevention programs provide community-based general suicide prevention education.			X	
9. IDPH will ensure that prevention programs include health providers and provide physician training and consultation about high-risk cases.				X
10. IDPH will ensure that prevention strategies include depression, anxiety, and suicide screening programs.			X	

b. Current Activities

Through state funds, IDPH contracted with Mental Health America of Illinois (MHAI) to implement suicide prevention activities. These activities included coordinating and implementing the Suicide Prevention Resource Center's (SPRC) two-day core competency training for communities interested in developing local suicide prevention coalition projects to assist in implementing the state plan. They also launched a public awareness campaign entitled "It Only Takes One." MHAI used IDPH funds to award seven mini-grants to appropriately qualified and trained organizations to train schools and school districts on suicide prevention. MHAI conducted training programs in the aging network during its annual conference. The University of Illinois Center for Prevention Research and Development evaluated these suicide prevention activities.

Chicago: CDPH does not specifically address adolescent suicide; however, most CDPH programs have policies and procedures related to crisis intervention, and provide clients with educational materials on depression and other conditions that can lead to suicide.

c. Plan for the Coming Year

IDHS will continue to work with the Illinois Coalition of School Health Centers to provide mental health counseling services. A standard encounter form has been developed to document mental health services provided at each site. Through use of discretionary funds, IDPH will monitor the prevention strategies as outlined in the Suicide Prevention, Education, and Treatment Act.

Through state funds, the IDPH will again contract with the Mental Health America of Illinois to implement additional suicide prevention activities. It is anticipated these activities will center on expanding the public awareness campaign, training professionals, supporting local initiatives and enhancing data. The activities will reflect the recommended next steps outlined in the Illinois Suicide Prevention Strategic Plan. IDPH will continue to facilitate the Illinois Suicide Prevention Alliance and their activities which will include meeting on a regular basis, creating an annual report and serving as an advisor to the Department.

Chicago. CDPH programs will continue to address crisis situations according to existing policies and procedures and provide clients with educational materials on depression and other conditions that can lead to suicide. Chicago Public Schools will continue to conduct the YRBS and monitor adolescent high risk behavior.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	83.5	83.5	81	82	83
Annual Indicator	81.0	83.1	82.6	81.4	81.4
Numerator	2375	2464	2427	2276	
Denominator	2932	2964	2938	2797	
Data Source				IDPH, Perinatal	IDPH, Perinatal
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	83	83	83	83	83

Notes - 2009
2009 birth data is not yet available. The 2008 Annual Indicator must be reported again for 2009.

Notes - 2008
Source: IDPH, Center for Health Statistics.

Notes - 2007
Source: IDPH, Center for Health Statistics.

a. Last Year's Accomplishments
In 2008, there was a slight decrease in the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. However, at 81.4, Illinois' performance on this measure exceeds the target set for 2008 (81 percent).

IDPH is working with the IDHS on the implementation and coordination of other MCH/perinatal programs and activities, such as the Fetal and Infant Mortality Review (FIMR) Project, Early Intervention (EI) Program and the Chicago Healthy Start Initiative.

IDPH and the Statewide Quality Council have worked closely with each of the 10 perinatal networks on the monitoring and evaluation of the percentage of the very low birth weight infants born in a Level II+ or Level III facility. The methodology for incorporating perinatal outcome surveillance and plans for improving provider compliance with consultation, referral, and transfer protocols for high-risk maternal and neonatal patients are in place at all facilities, as well as the monitoring system for outcomes for the purpose of quality assessment and improvement.

Chicago. In 2007, 912 very low birth weight infants were born to Chicago residents. Of these, 777 (84.1%) were born at Level III and Level II+ hospitals, locations capable of providing care for these infants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Each perinatal center uses continuous quality improvement to increase the proportion of infants born in Level II+ or Level III			X	

Centers.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Each of the 10 perinatal networks, as well as IDPH and the Statewide Quality Council, are monitoring and evaluating the percentage of very low birth weight infants born at appropriate facilities., The Director of IDPH, based on a recommendation from the Perinatal Advisory Committee (PAC), sent a letter introducing the Maternal Hemorrhage Education Project to the Perinatal Network administrators and to the chief executive officers of all hospitals providing maternity services in Illinois. The project was a response to the Maternal Mortality Review Committee's (MMRC) past and continuing findings that the majority of deaths occurred while women were hospitalized, these deaths occurred at every level of care throughout the state, and women from all socioeconomic groups were affected. The goal of the project is to improve and reduce maternal morbidity and mortality due to obstetric hemorrhage. The Obstetric Hemorrhage Project concluded in October 2009. All hospitals that were provided grants submitted an education and simulation drill schedule and conducted same. All grantees were addressing the development of a hospital specific hemorrhage assessment and rapid response policy. The status of policy implementation is addressed at re-designation site visits during 2010 and will be reported on in the 2010 year narrative.

c. Plan for the Coming Year

This performance measure will be addressed by IDPH through the routine operation of the Perinatal Program.

Chicago. The CDPH will continue to participate in Perinatal Advisory Committee meetings as necessary and assist in the development of perinatal rules and regulations. However, IDPH rather than CDPH will monitor the care provided by the Perinatal Centers and services provided by the Level II and Level II+ hospitals.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84	82	82	87	86
Annual Indicator	81.8	86.1	86.0	86.3	86.3
Numerator	146265	148860	145898	142671	
Denominator	178872	172853	169616	165348	
Data Source				IDPH, Center for Health Statistics	IDPH, Center for Health Statistics
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	87	87	87	87	87

Notes - 2009
2009 birth data is not yet available.

Notes - 2008
Source: IDPH, Center for Health Statistics, MCH Block Grant, Natality Data, 2008 (received 5/2010). An additional 11,286 infants were born to others with unknown trimester of prenatal care and excluded from the total number of births.

Notes - 2007
Source: IDPH, Center for Health Statistics, MCH Block Grant, Natality Data, 2007 (received 8/2008). These data have been revised and received along with the 2007 final data. An additional 10,914 infants were born to mothers with unknown trimester of prenatal care and excluded from the total number of births.

a. Last Year's Accomplishments
Illinois did not meet its newly established target of 87 percent of women who began prenatal care in the first trimester of pregnancy. The most recent data available, 2008, show that Illinois fell short by less than a percentage point: 86.3 percent of women began prenatal care in the first trimester.

Providers are encouraged to integrate WIC and FCM services in Illinois. When a pregnant or parenting woman presents for WIC certification, she will also receive information about Family Case Management, and vice versa. Often, she and her infant are enrolled in both programs at the same agency on the same day. Throughout her pregnancy, she will be encouraged to think about future contraceptive plans and she will be referred to Family Planning upon delivery. In many areas of the state, all three services are provided in the same agency. FCM workers engage in varied outreach activities within communities to encourage those who are pregnant or suspect a pregnancy to enroll in FCM and WIC in the first trimester. Eligible women who become pregnant while receiving services from Family Planning are referred to FCM and WIC as soon as there is confirmation of pregnancy.

The goal of IDHFS's Medicaid Presumptive Eligibility (MPE) program is to promote early and continuous prenatal care to low income pregnant women. Through presumptive eligibility, women are covered for prenatal care services from the date of the MPE determination. Approximately 3,800 women are enrolled in MPE each month.

The Targeted Intensive Prenatal Case Management Program target population consists of "hard to reach high-risk pregnant women" who reside in 14 target areas throughout Illinois. The most common risk factor for inclusion in the program is presence of a chronic disease that impacts pregnancy (25.2%), followed by greater than 4th pregnancy or third child expected (12.8%), and previous preterm birth (12.6%).

Chicago. In FY07, 35, 914 women (77.7%) in Chicago began prenatal care in the first trimester of pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FCM and other case management programs conduct outreach and case finding activities.		X		
2. Local health departments and WIC programs help women complete Medicaid Presumptive Eligibility applications.		X		
3. FCM and other case management programs help women obtain medical care.		X		
4. Family Planning programs conduct options counseling and refer women to prenatal care providers.	X			
5. IDHS and IDHFS partner with private foundations to improve outreach in targeted communities.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Local IDHS office staff are trained to routinely ask women of childbearing age if they are pregnant and, if so, to record this information in the Department's data system. This information is then shared with FCM and Chicago Healthy Start Initiative (CHSI) agencies, so staff can conduct outreach efforts and assist women with obtaining prenatal care.

Chicago. CDPH continues to conduct outreach activities to identify and recruit high-risk pregnant women, promote postpartum and family planning visits to decrease unplanned pregnancies, enroll women in care following a positive pregnancy test result, and encourage newly-pregnant women to continue in care.

c. Plan for the Coming Year

The Title V program will address this performance measure by continuing current strategies to increase the proportion of women who begin prenatal care in the first trimester, including referrals from Family Planning programs, outreach and case finding activities through Family Case Management, integration of WIC and FCM services, integration of TPS and FCM programs, and the operation of School Health Centers.

Chicago. CDPH's strategies of providing outreach to identify and recruit high-risk pregnant women, promoting postpartum and family planning visits to decrease unplanned pregnancies; enrolling women in care following a positive pregnancy test result, and encouraging newly pregnant women to continue in care will help reduce the number of women who delay early enrollment into prenatal care. CDPH has contracts with seven hospitals to provide midwifery-based prenatal and family planning services in five of its Neighborhood Health Centers.

D. State Performance Measures

State Performance Measure 1: *The incidence of maltreatment of children younger than age 18*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.7	7.9	7.8	7.8	8.8
Annual Indicator	7.9	7.6	8.1	8.6	8.5
Numerator	25571	24772	26399	27947	27453
Denominator	3220000	3240000	3240000	3240000	3240000
Data Source				IDCFS	IDCFS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8.7	8.6	8.5	8.5	

Notes - 2009
Source: Table 4, 2008 Annual Report, Illinois Department of Children and Family Services website. The denominator is an arbitrary number to arrive at the reported number and rate of children indicated as an unduplicated count within the State.

Notes - 2008
Source: Tables 4 and 8, 2008 Annual Report, Illinois Department of Children and Family Services website. The denominator is an arbitrary number to arrive at the reported number and rate of children indicated as an unduplicated count within the State.

Notes - 2007
Source: Tables 4 and 8, 2007 Annual Report, Illinois Department of Children and Family Services website. The denominator is an arbitrary number to arrive at the reported number and rate of children indicated as an unduplicated count within the State.

a. Last Year's Accomplishments
Rationale. This performance measure was selected in a prior five-year period. This performance measure was chosen to emphasize the importance of preventing child abuse and neglect.

The rate of child maltreatment has increased to 8.6 per 1,000 children; the rate was 8.16 per 1,000 children in 2007. Since 2006, the rate of child maltreatment increased 13 percent. Many factors underlie maltreatment, including financial insecurity. Perhaps the recent increase in child maltreatment is due in part to the worsening economic situation of many young families.

Healthy Families Illinois (HFI) seeks to prevent child abuse and neglect through intensive home visits that improve family functioning, enhance the parent child relationship, encourage positive parenting, and promote healthy growth and development. The IDHS currently supports 49 HFI programs throughout the state. The Parents Too Soon, Parents Care and Share and the High-Risk Infant Follow-up programs also address the prevention of child abuse and neglect.

Chicago. Recently mentioned as a promising approach by the Office of Juvenile Justice, the Chicago Safe Start (CSS) program was initially funded as national demonstration project in 2000 as a part of the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention's national Safe Start initiative. CSS' mission is to prevent and reduce the negative impact of exposure to violence on children ages six years and younger. This work is achieved through a balance of prevention and intervention efforts focusing on education, professional development, direct service innovation, and systems change oriented collaboration among city and state service providers, community organizations, and residents.

Since 2003, CSS has provided over 500 citywide training events reaching approximately 10,000 participants. Training evaluations conducted at least 18 months after participating in CSS training, show that 87 percent of participants were more aware of the problem of childhood exposure to violence, and 79 percent reported doing more personally to address childhood exposure to

violence. It's Bringing the Kids Back into Focus: Building a Community Response to Children's Exposure to Violence curriculum provides the main content for Safe Start trainings for community resident and professionals. Concerning clinical services to children (and their families), from 2002 to 2007, 1,629 children were referred to CSS contracted delegate agencies for exposure to violence services. Referrals and service are ongoing and are now tracked through the state program. Moving forward, CSS looks to new findings from a recent series of focus groups with parents in 10 Chicago communities to inform the ongoing process of refining the program's promotions and training efforts.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Healthy Families Illinois provides voluntary home visits to atrisk families with young children.		X		
2. Parents Too Soon programs provide home visits and peer groups to first time teen parents.		X		
3. Other teen parenting programs help clients develop effective parenting skills.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

HFI works with families who are at risk of child maltreatment. A goal of the intervention is to decrease the new and expectant parent's risk for child abuse and neglect by helping the parent to develop realistic expectations for child growth and development. Strengthening Families educates a network of childcare providers to utilize protective factors around families to build resiliency. Parents Care and Share is a network of parental support groups to prevent child abuse and neglect by helping parents to increase their protective factors.

Chicago. Chicago Safe Start (CSS) continues to partner with four service providers that provide family support and mental health services to children ages five years and younger who have been exposed to violence, along with their families. CSS convenes a collaborative of city and community partners who work on embedding CEV responsiveness into their respective domains of service. The program has worked to influence many systems (e.g. police) that have contact with infants and children exposed to violence.

c. Plan for the Coming Year

This performance measure has been eliminated for FFY '11.

State Performance Measure 2: *The proportion of CSHCN ages 14 and above and their parents who receive comprehensive transition planning services to promote awareness of adult services*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	**2005**	**2006**	**2007**	**2008**	**2009**

Performance Data					
Annual Performance Objective	77	80.9	85	81.9	82.8
Annual Indicator	80.8	82.2	81.7	82.7	83.6
Numerator	1651	1612	1574	1548	1574
Denominator	2043	1960	1926	1872	1883
Data Source				Record Review DSCC Youth 14-21	Record Review DSCC
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	82.8	82.9	82.9	83	

a. Last Year's Accomplishments

Illinois' performance objective to ensure that 82.8 percent of youth over 14 years of age and their parents receive comprehensive transition planning from DSCC staff was achieved. Actual performance in state FY '09 was 83.6 percent, which continues to improve slightly each year (SFY'08, 82.7 percent; SFY'07, 81.7 percent).

The agency developed a new Assessment Worksheet to assist DSCC care coordination teams with gathering information from families. The Assessment Worksheet was structured to gather information under four main sections to include: Medical or Health, Family, Educational or Vocational and Transition. If issues or needs are identified through assessment, the care coordination team works with the family to identify their goals. The Individualized Service Plan (ISP) was also revised to strengthen family involvement in the planning process including transition planning. Regional office staff were trained on the new assessment process and revised ISP in April and May, 2009. The agency's training activities, time and resources during this timeframe were focused to support these new enhanced processes. DSCC's training and technical assistance unit continued to provide transition training to new care coordinators and transition technical assistance requested from DSCC care coordination teams.

A review of all case records for youth ages 14-21 years shows that for those that had some aspect of transition addressed, 75.4 percent (74.7 percent in FY'08) received planning information on health care transition; 74.7 percent (76.2 percent in FY'08) received information on vocations; and 69.0 percent (68.3 percent in FY'08) on community involvement and integration. These data reflect only DSCC care coordination efforts in transition planning.

The DSCC transition work group continued to evaluate and revise DSCC's transition services and materials. Feedback from youth, families, and staff was gathered in an effort to continuously evaluate transition service needs and advice on anticipatory guidance, transition tools, resources and training needs.

DSCC supported 21 staff and 30 youth and family members' participation in the statewide transition conference held in Peoria, Illinois. DSCC provided three presentations at this conference including: "Creating a Care Notebook to Manage Your Own Healthcare;" "The Benefits of Having a Medical Home for Children with Special Health Care Needs;" and "Strategies, Hands On Tools and Referral Resource Information for Health Care Providers to Use with their Adolescent Patients to Promote Successful Transitions." DSCC was also an exhibitor and provided health care transition outreach materials and information.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical transition materials available on website.				X

2. Care coordination staff development on transition.				X
3. Evaluation of transition planning.				X
4. Promoting awareness of transition issues/resources.				X
5. Care coordination related to transition planning for DSCC children and youth.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DSCC Transition Work Group subcommittees have compiled a list of post-secondary resources to be added to DSCC's Internet page on transition, including colleges and universities with specific programs for students with disabilities or chronic illnesses. "Transition Milestones' Skills Lists" have been developed and will soon be ready for use. The skills lists address Medical, Educational, Financial, Living Arrangements, Social and Recreational and Employment concerns and are to be completed by youth (with assistance as needed) to assist with identifying their skills and to set goals. Teaching sheets have been revised and additional teaching sheets have been developed for use with the skills lists. Recommendations include development of a brief PowerPoint presentation for outreach to low-literacy youths and families. The goal-setting training curriculum has been implemented with six of thirteen offices and training of the remaining offices will be completed by the end of SFY'10. DSCC staff members involved in DSCC-sponsored clinics were surveyed and identified opportunities to address transition during clinic visits. Staff also recommended providing an in-service on transition related resources for physicians staffing these clinics.

c. Plan for the Coming Year

A recent chart review found 48.1 percent of youth, aged 14-21 years, have a written DSCC transition plan. This is a significant improvement from 18.1 percent in FY'08. The agency has required all DSCC-registered CYSHCN to have a new Assessment Worksheet and new ISP completed by September 2010. Staff are encouraged to address transition planning on the ISP for all transition age youth and young adults.

DSCC care coordination staff will strengthen transition efforts for recipients by working to improve access to high quality, developmentally appropriate, uninterrupted healthcare through facilitating transition to adult health care providers, referring to appropriate resources, providing anticipatory guidance and writing person-centered plans. DSCC regional staff will continue to collaborate with community-based transition partners to strengthen and build community- infrastructure that coordinates the efforts of the health, social, education and employment systems.

The transition work group will continue to evaluate and improve DSCC's transition tools and materials. Feedback from youth, families, and staff will be gathered in an effort to continuously evaluate transition service needs and advise on anticipatory guidance, transition tools, resources and training needs.

DSCC's administrative staff continues to work with the Medical Advisory Board members and experts to identify adult health care providers in Illinois trained, willing and ready to care for youth and young adults to assist with transition to the adult health care system. DSCC's approval criteria for adult congenital heart disease specialists and centers have been developed and are currently in the review process. Efforts to improve transition from pediatric to adult health care providers for all CYSHCN will continue through training, service coordination, and facilitation of medical home quality improvement teams.

State Performance Measure 3: *The proportion of women and children up to 22 years of age who receive appropriate genetic testing, counseling, education and follow-up services*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.5	1.5	1	1	1
Annual Indicator	1.0	1.0	1.0	1.3	1.4
Numerator	61099	61056	60455	81038	88025
Denominator	6091399	6091399	6091399	6091399	6091399
Data Source				IDPH, Genetics	IDPH, Genetics
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1	1	1	1	

Notes - 2009
Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2008), Genetics Program. Data updated 6/30/10.

The 2000 Census estimate was provided by the Genetics Program in 2001 only and have been applied for the trend to the last year (2009).

Notes - 2008
Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2008), Genetics Program. Data updated 6/30/10.

The 2000 Census estimate was provided by the Genetics Program in 2001 only and have been applied for the trend to the last year (2008).

Notes - 2007
Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2007), Genetics Program. The 2000 Census estimate provided by the Genetics Program was not reported until 2001 and will be continually used for this measure.

A change in data collection procedures resulted in a reduction in this performance measure. A data audit determined that in the past, service providers reported the number of individuals screened rather than the number referred for a genetic condition or concern. Guidelines were refined in an effort to capture the number of clients actually referred rather than merely screened. The performance target was lowered to 1.0 percent to reflect this change in practice. And, although, the performance target was met, the goal was not.

a. Last Year's Accomplishments
This performance measure was chosen because Illinois has a substantial number of newborns, children, and adults whose genetic conditions necessitate extensive and coordinated health care services. Although local health agencies and genetic centers do receive minimal funding, there remain communities that seriously lack any resources to meet such needs. This performance measure is placed at the direct health care level of the pyramid, and is considered a risk factor type of service. This measure will be addressed by IDPH.

Illinois met its goal of increasing the proportion of women and children who receive genetic testing, counseling, education, and follow-up services.

The IDPH Genetic Counseling and Education Program staff provided technical assistance to local health departments, clinical geneticists, and other specialists who received funding. Local health departments received funding for nurses to serve as case managers, facilitators, educators, and referral sources for all clients in need of any service related to genetics. Clinical genetics centers received funding to provide diagnosis, counseling, treatment, and long range management to pediatric and adult patients. Satellite clinics have been staffed by medical geneticists in collaboration with specific local health departments.

Chicago. In 2009, 1,593 prenatal clients in the CDPH clinics were screened for genetic disorders. Of these, 163 (10 percent) were referred for follow-up. Of those, 160 (98 percent) kept their appointments. During FY2009, the Chicago Department of Public Health received 765 referrals for infants up to one year old for genetic disorders. Public Health nurses made 161 referrals for family counseling and 508 referrals for genetics follow-up. Ten newborns were screened for cystic fibrosis and seven were referred to a geneticist for follow up.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. IDPH awards grants to medical centers for diagnostic, counseling and treatment services.		X		
2. IDPH awards grants to local health departments for genetic case-finding and referral		X		
3. IDPH awards grants to pediatric hematologists at medical centers.		X		
4. IDHFS reimburses for preconceptional risk assessment.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This performance measure is addressed through the routine operation of IDPH's Genetic Counseling program.

Chicago. CDPH Maternal and Family Planning programs routinely screen for genetic disorders in community health clinics, and provide genetics education. The genetic screening tool is incorporated in all home visits. Public health nurses continue to provide genetic health teaching at CDPH clinics, WIC, Family Case Management and day care programs.

c. Plan for the Coming Year
This performance measure will not be continued for FFY'11.

State Performance Measure 4: *The prevalence of Early Childhood Caries (ECC)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	33	33	33	33	33
Annual Indicator	33.0	33.0	30.4	30.4	26.7
Numerator	175000	175000			1421
Denominator	530600	530600			5317
Data Source				IDPH, Oral Health	IDPH, Oral Health
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	33	33	30	30	

Notes - 2009
The 2009 indicator is based on data from the 2009 Head Start Oral Health Status data collection, per Oral Health - IL Dept. of Public Health.

In 2009, the Division of Oral Health provided early childhood caries educational tools and supplies to the following WIC participants: 35,291 infants; 62462 children; 14,497 pregnant moms and 11,647 other moms.

Notes - 2008
IDPH, Oral Health has no new data for 2008. After 2010 they may have new data.

Notes - 2007
According to the Oral Health program at IDPH, "ECC prevalence - our Headstart BSS 2006-07 found that at the state level 30.4% of children in Head Start had caries experience." IDPH continues to report only the percentage to the MCH program. Form 16 has been revised for the 2009 application. Beginning with the 2007 annual report, only the percentage will be reported.

a. Last Year's Accomplishments
This performance measure was chosen because 12 of the 19 Illinois communities completing an oral health needs assessment and comprehensive oral health plan in 1997 identified Early Childhood Caries (ECC), or "baby bottle tooth decay," as an oral health priority.

In 2001, the IDPH Division of Oral Health (DOH) completed a statewide prevalence study of ECC in children participating in the WIC program. The study found 33 percent of the children presented with ECC. The IDPH Division of Oral Health completed a comparable study in 2006. The DOH's epidemiologist completed the analysis of the 2006 ECC Basic Screening Survey (BSS) of 2 to 4 year olds in Head Start. The BSS has yielded oral health status of the children as well as a uniform method for ongoing data collection. Preliminary data shows a 30 percent ECC rate in the children screened.

The IDPH DOH, the IDHS WIC program, and the Head Start programs in Illinois are implementing a statewide oral health education program for women, infants and children participating in the WIC and Head Start programs. The program goal is to improve the oral health status of pregnant women and very young children through oral health education. The educational tools were developed based on a survey of the WIC Program Certified Health Professionals.

The IDPH DOH and Illinois Chapter of the American Academy of Pediatrics (ICAAP) created a training program to teach pediatricians to apply fluoride varnishes, screen children, provide anticipatory guidance, and refer families to dentists for oral health care. IDPH and ICAAP joined with IDHFS and the UIC College of Dentistry to implement a research project to study the efficiency and efficacy of fluoride varnishes applied by pediatricians in MCH settings. This initiative is designed to improve oral health status of children by encouraging a focus on oral

health screening and anticipatory guidance in primary care practices, as well as promoting a dental home with a dentist for ongoing preventive and needed treatment services. Training was provided to physicians in Chicago and the surrounding counties to apply dental varnishes to young children (under age 3 who have at least four teeth), in the course of regular well-child visits. Those trainings continued in 2009 and will continue each year in the new application period. The project includes an evaluation component to determine its efficacy in improving oral health. Results from the prior year evaluations show that the trainings and the implementation of the practice by pediatricians is having a positive impact on how parents view their child's oral health. Based on provider surveys, this initiative appears to be resulting in children getting into dental care earlier and appears to be affecting physician perceptions and focus on oral health, resulting in dental referrals, more attention being paid to dental issues in the primary care setting, and anticipatory guidance. In 2009,the initiative was expanded to include Federally Qualified Health Centers (FQHCs) downstate. The IDPH DOH assures that families of children with special health care needs receive the oral health education and referral to dental homes by working with DSCC.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. IDPH works with interested communities to establish community-based prevention programs.				X
2. IDHFS supports a pilot test of the application of fluoride varnish.	X			
3. IDHFS' contractor, Doral Dental, conducts outreach to All Kids-eligible children who have not received a dental service for 12 months.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

IDPH continues to implement the ECC prevention project based on recommendations found in the Illinois Oral Health Plan II (IFLOSS 2007). The program is building oral health infrastructure within MCH programs. IDPH expanded the training portion of the program to additional IDHS programs, such as Coordinated Child Care, Teen REACH, WIC, FCM, and Head Start, and is providing them incentives of toothbrushes, dental floss, toothpaste and other oral health educational tools.

A data collection process is in place to complete the annual ECC Basic Screening Survey (BSS) of 2 to 4 year olds in Head Start. The BSS will yield oral health status of the children and a uniform method for ongoing data collection.

The IDPH DOH has expanded the ECC Prevention Program efforts by funding the creation of an Oral Health Network, which focuses on safety net clinics through the Illinois Primary Health Care Association. The IDPH DOH has implemented seven community-based ECC Prevention Planning Projects to yield comprehensive community-based plans including outcomes, strategic interventions.

c. Plan for the Coming Year
This performance measure will not be continued for FFY'11.

State Performance Measure 5: *The prevalence of childhood lead poisoning*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	4.6	2.9	2.8	2.7	1.8
Annual Indicator	3.0	2.3	1.8	1.7	1.7
Numerator	8123	6480	5270	5126	5126
Denominator	275103	278078	296998	304807	304807
Data Source				IDPH, CHLPPP	IDPH, CHLPPP
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1.8	1.8	1.8	1.8	

Notes - 2009
Source: Illinois Lead Program - IDPH - 3/24/10. Data is provisional; it is unknown when the data will be finalized.

Notes - 2008
Source: Illinois Lead Poisoning Prevention Program.

Notes - 2007
Source: IDPH, Illinois Lead Program Annual Surveillance Report 2007, Summary Statistics.

a. Last Year's Accomplishments
Rationale. The Healthy People 2010 objective is to eliminate the prevalence of blood lead levels exceeding 10 µg/dL in children aged 6 months through 6 years. Illinois' provisional rate of lead poisoning reported for 2009 is 1.5 percent. Illinois has met this Healthy People 2010 objective.

The program achievements in 2009 include: development of a quick reference poster entitled "Choice of Medical Management Based on Symptoms and Blood Lead Concentration -- Guidelines for the Detection and Management of Lead Poisoning for Physicians and Health Care Providers" for distribution to physicians and health care providers for ease in determining risk assessment for lead poisoning and medical management of a child with an elevated blood level; expansion of the Illinois Childhood Lead Poisoning Elimination Advisory Council to involve an increased number of non-traditional and faith-based organizations; offering of contact hours for nurses to include a healthy homes segment to increase attendance and provide additional information at trainings offered to local health department staff and health care providers; and conducting several informational meetings to inform contractors, landlords and property management organizations of the upcoming U.S. EPA Renovation, Repair and Painting rule.

Chicago. Based on 2009 preliminary data, 106,501 children aged 0 to 72 months were tested in Chicago. Of those tested, 1,507 children were identified with blood lead levels greater than or equal to 10 µg/dL. High risk neighborhoods have continued to outpace the city as a whole with high prevalence of lead poisoning, even though the numbers of children with elevated blood lead levels are declining. The screening rate among children has remained the same over the last five years. Chicago Department of Public Health (CDPH), focuses testing on children three years of age and younger to identify exposure to paint and non-paint lead hazards. The CDPH strives to assure that those children needing follow-up services receive them by providing follow up blood

lead testing and education. For high-risk young children, CDPH conducts public health nurse home visits and home investigations to determine the source of lead poisoning. In 2008, 2,306 children in Chicago had blood lead levels higher than or equal to 10 micrograms per deciliter. As scientific evidence that children's physical and mental development can be affected at blood lead levels of < 10mcg/dl, CDPH strengthened established initiatives, strategic plans and partnerships created to eliminate and/or reduce the impact of lead poisoning on communities. CDPH continues to focus screening efforts on Chicago's high-risk neighborhoods in the south and west sides of the city. Blood lead levels continue to decline at a rate exceeding that of other major cities.

Chicago program achievements in 2009 include: collaboration efforts between CDPH and Environmental Protection Agency to report and prosecute violators of the Lead Based Paint Disclosure Rule, Section1018. This rule requires the disclosure of known information on lead-based paint and lead-based paint hazards before the sale or lease of most housing built before 1978. CDPH conducts voluntary chart audits to determine the percentage of children testing in high risk area clinics. Evaluation efforts demonstrated a 20 to 25 percent increase in compliance for participating clinics. On the national level, the collaboration with the National Center for Healthy Housing, related to a University of Illinois demolition research study increased the awareness of leaded dust surrounding demolition sites.

Other Chicago program highlights from the past year include: CDPH continues to implement the requirements of the new Illinois Lead Poisoning Prevention Act, passed on June 20, 2006. Working with Action for Children, all childcare providers received information packets about lead poisoning prevention, free lead poisoning prevention training, and information on how and when to provide lead poisoning information to parents enrolled in childcare programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to increase the number of at-risk children screened for lead poisoning.	X			
2. Maintain a statewide Lead Elimination Advisory Council.				X
3. Maintain local advisory committees.				X
4. Continue to coordinate activities with lead hazard reduction grant programs.				X
5. Educate pregnant women and families with children under three years of age about lead poisoning through WIC clinics and Perinatal birthing hospitals.		X		
6. Train medical residents and nursing students on appropriate clinical management of lead-poisoned children.				X
7. Expand efforts with high-risk targeted areas to educate the public about lead poisoning prevention methods, intervention procedures, and safe home renovation practices.				X
8.				
9.				
10.				

b. Current Activities

The Illinois Lead Program contracts with 81 delegate agencies to provide case management care for lead poisoned children in 89 of the 102 counties. The remaining counties are case managed by the ILP Regional Nurse Consultants. Quarterly data match reports are generated following the interagency agreement by the IDPH and the IDHFS to identify, screen, and provide follow-up services to HFS enrolled children at risk of exposure to lead-bearing substances.

The ILP data management section is working with the Division of Information Technology to replace the current STELLAR (Systematic Tracking of Elevated Lead Levels and Remediation) system. The new system will enhance data collection, monitoring lead levels at the delegate agency level, increase electronic reporting capabilities from laboratories as well as the transmission of reports to the local health departments and the Centers for Disease Control and Prevention (CDC). This electronic reporting system should increase the accuracy in reporting to at least 95 percent and greatly reduce the lead reports error file.

Chicago: CDPH provides free blood lead testing at WIC sites throughout Chicago's high-risk neighborhoods. Lead Safe Chicago, a strategic plan to increase blood lead screening rates among children, increase awareness among decision makers, identify additional funds and motivate property owners to provide more affordable lead safe housing, continues to contribute to the reduction in lead poisoning in Chicago.

c. Plan for the Coming Year
This performance measure will not be continued for FFY'11.

State Performance Measure 6: *The rate of unintended pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		43.5	43	42.5	42
Annual Indicator	42.2	41.7	42.9	42.9	42.9
Numerator		70931	73087		
Denominator		170006	170247		
Data Source				IDPH, PRAMS	IDPH, PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	41.5	41	41	41	

Notes - 2009
The latest PRAMS data available from the Illinois Department of Public Health are 2007.

Notes - 2008
The latest PRAMS data available from the Illinois Department of Public Health are 2007.

Notes - 2007
The latest PRAMS data available from the Illinois Department of Public Health are 2007.

a. Last Year's Accomplishments
This performance measure was added to highlight the rate of unintended pregnancy in Illinois, particularly among Medicaid-eligible women. This health problem was identified through the needs assessment completed for the FFY'06 application and reaffirmed by the FFY'11 needs assessment. This objective will be addressed through the provision of family planning services through the Title X and School Health Center programs, through the Teen Pregnancy Prevention Programs (both Primary and Subsequent) and through interconceptional care provided by the Family Case Management program and Chicago Healthy Start Initiative. It addresses the "direct health care" level of the pyramid and is a "risk factor" service.

Annual performance is measured through Illinois' PRAMS survey. The most recent data available

are from 2007. That year, 42.9 percent of pregnancies resulting in live births were unintended. This is a slight increase from the 2006 report of 41.7 percent. The Healthy People 2010 goal is to increase percent of intended pregnancies to 70 percent. Teens continue to represent the highest proportion of unintended pregnancies when compared to other age groups. Black women represent the highest percent of women with unintended pregnancies (68.5%), as do those who are not married (67.1%). Women whose deliveries are paid for by Medicaid (59.2%) have a rate of unintended pregnancy more than double that of women whose deliveries are paid for by other means (25.4%). There has been no significant decline in rate of unintended pregnancy in Illinois from 2003-2007.

This performance measure was addressed through the routine operation of the Family Planning program, the School Health Centers, and the Primary and Subsequent Teen Pregnancy Prevention programs.

In June 2009, a satellite training on Male Reproductive Health was provided. The statewide Preconception/Interconception Care Committee developed a comprehensive training curriculum on pre/interconceptional health, and began conducting trainings for FCM, WIC, Family Planning and FQHC provider groups in April 2009. A total of nine training programs were conducted across Illinois between April and July 2009, for various provider groups. The training modules will be posted on the IDHS website along with various tools and handouts as a resource for anyone who wishes to use them. In June 2009, all Healthy Start sites joined a national Interconceptional Care Learning Collaborative. The four Chicago Healthy Start sites received training on pre/interconceptional care in October 2009 and began use of Reproductive Life Plans with enrolled clients this January.

In 2009, all state Title X delegate agencies were mandated to increase enrollment in Illinois Healthy Women. A portion of their funding was tied to success in this endeavor. As a result, there has been a significant increase in the number of women accessing family planning services who are covered by Illinois Healthy Women.

Chicago. During 2008, due to data issues with the CERNER computer system, the number of distributed doses of emergency contraception in community health clinics, the percent of contraception users who received an extended exam to obtain highly effective hormonal contraceptives, and the percent of users choosing hormonal methods are unavailable. During 2009, Family Planning staff provided 31 outreach educational sessions to 1,532 participants in Chicago communities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide Family Planning services.	X			
2. Provide contraceptive services through School Health Centers.	X			
3. Provide education and other youth development interventions to prevent teen pregnancy.		X		
4. Provide interconceptional case management.		X		
5. Collaborate with IDHFS Illinois Healthy Women program.				X
6. IDHFS expands the eligible population upon approval of a federal waiver request.				X
7.				
8.				
9.				
10.				

b. Current Activities
The Family Planning program's current activities to reduce the rate of unintended pregnancy include: 1) Offer a broad range of highly effective methods of contraception, including the provision of emergency contraception; 2) Participate in the ongoing promotion, evaluation, and data collection for the Illinois Healthy Women Medicaid Waiver; 3) Provide preconception education, including information about the importance of birth planning and spacing;4)Promote the use of birth control through sexually transmitted disease clinics; 5) Continue efforts to improve awareness of and access to emergency contraception; and 6) Monitor delegate agency outreach education activities to the target population to educate on the prevention of unintended pregnancies.

Chicago. The CDPH addresses unintended pregnancy through all of its MCH programs, but in particular the Family Planning, Male Responsibility, and Healthy Start programs.

c. Plan for the Coming Year
The Department will address unintended pregnancy through the routine operation of the Family Planning and School Health Center programs, the Teen Pregnancy Prevention Programs (both Primary and Subsequent) and by providing interconceptional care through the Family Case Management program and the Chicago Healthy Start Initiative.

Chicago. CDPH will continue to address unintended pregnancy through Family Planning, Healthy Start and Interconceptional Care programs.

State Performance Measure 9: *The proportion of children under 36 months of age in WIC or FCM who have received at least one developmental screening test in the previous 12 months*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		63	66	66.5	67
Annual Indicator	60.6	64.4	66.1	66.1	59.4
Numerator	28901	29775	33248	34772	37484
Denominator	47671	46200	50302	52595	63154
Data Source				IDHS, Cornerstone	IDHS, Cornerstone
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	68	69	71	71	

Notes - 2009
Source: Illinois Department of Human Services, Community Health and Prevention, Cornerstone Q1, SFY2010. This is a special report run because effective 7/1/2009, the WIC Program counts are not part of the standard reporting. This is because WIC does not enter screening data as part of their assessment.

Notes - 2008
Source: Illinois Department of Human Services, Community Health and Prevention, Cornerstone Q1, SFY2009.

Notes - 2007

Source: Illinois Department of Human Services, Community Health and Prevention, Cornerstone Q1, SFY2008.

a. Last Year's Accomplishments
This performance measure highlights the unique role that the MCH program can play in identifying children who are experiencing developmental delays and ensuring that they have access to appropriate treatment.

The FCM program implemented a new policy for developmental screening. This new policy provided for: developmental screenings on infants and children between 3 and 66 months; that an approved tool is to be used; that a licensed individual (R.N., Nutritionist, Social Worker or individuals with advanced degrees in child health) is to perform the screening; that a referral is made to Early Intervention when appropriate; and that follow-up occur to ensure referral was successful.

Chicago. In FY 2009, 6,860 (6.84%) CDPH children age birth to 36 months received developmental screenings. Four hundred and sixty-nine (469) of these were abnormal. The children were referred for follow-up.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct developmental screening through the WIC and Family Case Management programs.		X		
2. Conduct developmental screening through the Healthy Families Illinois, Parents Too Soon, and Teen Parent Services programs.		X		
3. Provide additional training on early childhood development to Family Case Management, WIC, Healthy Families Illinois, Parents Too Soon, and Teen Parent Services providers through the State Early Childhood Comprehensive Systems initiative.				X
4. Refer children who appear to have a developmental delay to the Part C Early Intervention program for further assessment.		X		
5. The All Our Kids Early Childhood Networks will coordinate or promote developmental screening in the communities they serve.				X
6. The MCH program will participate in the Early Learning Council and the Early Childhood Committee of the Illinois Children's Mental Health Partnership.				X
7. IDHFS leads the Assuring Better Child Development II and Enhancing Developmentally-Oriented Primary Care projects.				X
8.				
9.				
10.				

b. Current Activities
IDHS partnered with staff from the EDOPC project to provide comprehensive training on child development issues to an array of providers across the state. Local WIC agencies refer families to the Early Intervention Program as needed. Follow-up is documented in case notes.

The EDOPC training project will continue, and will be offered to IDHS Child Care Nurse Consultants, so they can train licensed day care providers. It also will be offered to members of the AOK networks.

Chicago. CDPH FCM staff administers the Denver Developmental Screening Test, and verifies receipt of other developmental screening. Other CDPH programs that monitor and facilitate receipt of developmental screenings include the Greater Westside of Chicago Early Childhood Network, and the greater Englewood Healthy Start Initiative. The CDPH also has an agreement with the Early Intervention Program to screen children in the WIC Program.

c. Plan for the Coming Year
This performance measure will not be continued for FFY'11.

State Performance Measure 10: *Females 15 to 24 years of age receiving services at Title X family planning clinics tested at least once for chlamydia*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective			57	58	59
Annual Indicator	55.9	55.1	55.9	52.1	54.9
Numerator	47645	43503	41040	38456	34677
Denominator	85178	78908	73478	73749	63166
Data Source				IDPH & IDHS Family Planning	IDPH & IDHS Family Planning
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	61	61	61	

Notes - 2009
Source: 2009 FPAR

Notes - 2008
Source: 2008 FPAR

Notes - 2007
This is a new state performance measure being introduced before the end of the needs assessment cycle. Therefore the Annual Performance Objective technically may not be measured until the 2007 annual report. The measure will indicate performance of the Family Planning program in collaboration with the STD Section at IDPH for identifying and treating chlamydia among young females. Source: 2007 FPAR

a. Last Year's Accomplishments
In 2009, IDPH reported that 55.3 percent of females less than 25 years of age receiving services at Title X Family Planning Clinics received at least one test for Chlamydia.

The Family Planning program and the IDPH STD program undertook the following in FY'09 to reduce the rate of Chlamydia: Testing all clients less than 26 years of age including clients seeking pregnancy testing; retesting persons with positive tests three months after treatment to detect reinfection; testing of partners of family planning clients with positive test results; and initiating Expedited Partner Therapy when proposed legislation became law in Illinois.

Chicago. The CDPH Office of STD Surveillance reports on residents of Chicago between 15 and 25 years of age with Chlamydia. Non-Hispanic Blacks are disproportionately impacted by Chlamydia. During CY2009, the CDPH Family Planning clinics conducted 2721 tests on family planning clients for Chlamydia, and 2719 tests for gonorrhea. One hundred and sixty-six (6.1%) of Chlamydia tests were positive; while 46 or 1.7% were positive for gonorrhea.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Family Planning services.	X			
2. Provide STI testing and treatment through School Health Centers.	X			
3. Collaborate with the IDPH Sexually Transmitted Disease Program and AIDS Activity Section.				X
4. Participate in the Region V and Illinois Infertility Prevention Projects.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During SFY2010, the Illinois Infertility Prevention Project initiated a Family Planning clinic self-assessment to determine adherence to the screening criteria for Chlamydia and Gonorrhea infection. The IDPH STD Section, the IDHS Bureau of Community Health Nursing and Family Planning program staff utilized the information gathered from the self assessments and the ongoing tracking of "timeliness to treatment" data to focus educational efforts on the delegate agencies not meeting performance measures.

Chicago. CDPH policy mandates all pregnant women be screened at least once during their pregnancy. CDPH's STD/HIV/AIDS Division Adolescent Program and HIV Counseling and Testing unit and key CPS staff have revised CPS's confidentiality and Sexually Transmitted Infection (STI) policy/procedures/protocol. The revised policy/protocol allows STI counseling and testing to occur in all high schools whether or not there is a school based health clinic. The adolescent program also re-established collaborations with the Illinois Youth Center-Chicago and with the YMCA.

c. Plan for the Coming Year

This performance measure will not be continued in FFY'11.

E. Health Status Indicators

Introduction

Data for Health Status Indicators 1 through 12 are presented on Forms 20 and 21.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.6	8.6	8.5	8.4	8.4
Numerator	15296	15607	15370	14836	
Denominator	178872	180503	180530	176634	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data are not available from IDPH for 2009 births. IDHS has no control over the processing or release of the State of Illinois Birth File. Therefore the rate for 2009 uses the rate from 2008 as an estimate. The approximate due date of the 2009 Birth File is May 2011.

Notes - 2008
Source: 2008 Birth file - IDPH, Vital Records.

Notes - 2007
Source: 2007 Birth file - IDPH, Vital Records.

Narrative:
The percent of live births weighing less than 2,500 grams has remained stable, fluctuating by a 10th of a percentage point year after year since 2005. The DHS and its partners have instituted several initiatives to lower this rate. The Title V program uses an array of services to improve pregnancy outcomes, including direct health care, enabling and population-based services. Direct health care services are provided through the "mini" block grant awarded to the CDPH and, on a limited basis, through the FCM program. Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Family Case Management (FCM).

The Department also operates two initiatives that are targeted to communities with high rates of low birth weight and infant mortality. IDHS was awarded one of the original 15 Healthy Start projects to serve six community areas in Chicago's inner city. IDHS subsequently implemented Targeted, Intensive Prenatal Case Management to serve high-risk pregnant women in several target communities across the state.

The Family Planning and IDHFS' Illinois Healthy Women (IHW) programs are the state's primary strategies for improving preconceptional health. The Family Planning program provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. Services include client education, counseling, screening, infertility services, pregnancy testing and options counseling, contraceptive methods, and identification and treatment of sexually transmitted infections. Services are available statewide through a network of delegate agencies. IHW was implemented as a five-year waiver in April 2004; a complete description may be found in Section III of this application, under "Health Care Financing."

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	6.6	6.7	6.5	6.4	6.4
Numerator	11360	11619	11345	10944	
Denominator	172105	173860	173787	169898	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data are not available from IDPH for 2009 births. IDHS has no control over the processing or release of the State of Illinois Birth File. Therefore the rate for 2009 uses the rate from 2008 as an estimate. The approximate due date of the 2009 Birth File is May 2011.

Notes - 2008
Source: 2008 Birth file - IDPH, Vital Records.

Notes - 2007
Source: 2007 Birth file - IDPH, Vital Records.

Narrative:
The absolute number of births and the percent remained relatively stable from 2005 to 2007 but in 2008 both the number of LBW births and the LBW percent declined. This decline is anticipated to continue into 2009.

Please refer to the narrative for Health Status Indicator 1A for more discussion.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.6	1.6	1.6	1.6	1.6
Numerator	2932	2964	2938	2797	
Denominator	178872	180503	180530	176634	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data are not available from IDPH for 2009 births. IDHS has no control over the processing or release of the State of Illinois Birth File. Therefore the rate for 2009 uses the rate from 2008 as an estimate. The approximate due date of the 2009 Birth File is May 2011.

Notes - 2008
Source: 2008 Birth file - IDPH, Vital Records.

Notes - 2007
Source: 2007 Birth file - IDPH, Vital Records.

Narrative:
The absolute number of births and the percent remained relatively stable from 2005 to 2007 but in 2008 the number of VLBW births declined. However, the total number of all infants born also dropped so the percentage remained the same. The rate is anticipated to be constant into 2009.

Please refer to the narrative for Health Status Indicator 1A for further discussion.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.2	1.2	1.2	1.2
Numerator	2088	2167	2072	1992	
Denominator	172105	173860	173787	169898	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data are not available from IDPH for 2009 births. IDHS has no control over the processing or release of the State of Illinois Birth File. Therefore the rate for 2009 uses the rate from 2008 as an estimate. The approximate due date of the 2009 Birth File is May 2011.

Notes - 2008
Source: 2008 Birth file - IDPH, Vital Records.

Notes - 2007
Source: 2007 Birth file - IDPH, Vital Records.

Narrative:
The percent remained relatively stable from 2005 to 2007 but in 2008 the number of VLBW births declined for the first time below the 2,000 threshold. However, the total number of all infants born also dropped so the percentage remained the same. The rate is anticipated to be constant into 2009.

Please refer to the narrative for Health Status Indicator 1A for more discussion.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	5.7	6.9	5.6	5.6	5.6
Numerator	147	181	147		
Denominator	2566155	2640114	2631525		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2008 and 2009 death data is provisional.

Notes - 2008
2008 and 2009 death data is provisional.

Notes - 2007
Source: IDPH - Vital Records and the Center for Health Statistics. Denominator from the Census population estimates.

Narrative:
The number of deaths to children aged 14 years and younger decreased in 2007 as compared to 2006; there were 34 fewer deaths for a rate of 5.6 per 100,000.

In 2009 representatives from the Illinois Department of Children and Family Services' Child Death Review Program, the Illinois Department of Human Services' Maternal Child Health Program and the IDPH Injury and Violence Prevention Program formed a team to represent Illinois at the "Keeping Kids Alive" Symposium hosted by the National Center for Child Death Review and the Children's Safety Network. The Illinois team will continue to meet during 2010 to look for initiatives to collaborate on.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	2.0	2.1	2.5	2.5	2.5
Numerator	56	58	65		
Denominator	2752100	2720397	2631525		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5					

and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Death data for 2008 and 2009 is provisional.

Notes - 2008
Death data for 2008 and 2009 is provisional.

Notes - 2007
Source: IDPH - Vital Records and the Center for Health Statistics. Denominator from the Census population estimates.

Narrative:
Illinois experienced an increase in the rate of motor vehicle crash deaths among children between 1 and 14 years of age to 2.5 per 100,000 children.

IDPH continued its partnership with the Chicago Police Department, the Illinois State Police, local hospitals and health centers, and IDCFS to conduct community child safety seat checks. Through this partnership, 45 safety seat checks were held, and 1,400 car safety seats were distributed to low-income families, and more than 3,000 car seats were checked for proper seat installation. During a car seat check clients are taught how to properly use seat belts as well as proper car seat installation.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	20.7	17.6	18.8	18.8	18.8
Numerator	379	328	350		
Denominator	1829459	1866573	1857288		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Death data for 2008 and 2009 is provisional.

Notes - 2008
Death data for 2008 and 2009 is provisional.

Notes - 2007
Source: IDPH - Vital Records and the Center for Health Statistics. Denominator from the Census population estimates.

Narrative:
The rate of death from unintentional injuries due to motor vehicle crashes among youth who were between 15- and 24-years-of-age increased by a percentage point from 2006 to 2007 (17.6 to 18.8 per 100,000, respectively). These deaths resulted in many years of potential life lost. One significant factor associated with motor vehicle crashes among this age cohort is alcohol consumption. DHS is administering a SAMHSA Statewide Incentive Grant, Partners for Success, which is addressing under-aged drinking as well as alcohol use among young adults in community areas throughout Illinois. The communities utilize an array of prevention techniques to reduce alcohol consumption.

Underage drinking also is addressed by funding provided by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) grant programs called Enforcing Underage Drinking (EUDL). The purpose of the grant is to support the reduction of the availability of alcoholic beverages to and the consumption of alcoholic beverages by persons who are younger than 21 years old. The EUDL Block Grant supports enforcement strategies aimed at limiting retail and social access. The EUDL University Initiative targets two campuses and communities in the state. Each grantee is expected to work in partnership with a coalition and have developed a strategic plan and is implementing evidence-based enforcement and policy strategies in coordination with community education activities.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	334.3	318.4	323.5	325.4	325.5
Numerator	9028	8662	8552	8566	8583
Denominator	2700253	2720397	2643433	2632062	2636730
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The number of non-fatal injuries is hospital discharge data. The addition of additional diagnoses codes starting in 2008 only added a small percentage more than using the previous method of reporting.

Sources: IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2009 Illinois Population Estimates, U.S. Census Bureau.

Notes - 2008
The number of non-fatal injuries is hospital discharge data. The addition of additional diagnoses codes in 2008 only added a small percentage more than using the previous method of reporting.

Sources: IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2008 Illinois Population Estimates, U.S. Census Bureau.

Update: Figures for 2008 revised due to new data provided by IDPH, Office of Policy, Planning and Statistics on 7/1/2010

Notes - 2007
The number of non-fatal injuries is hospital discharge data.

Sources: IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2007 Illinois Population Estimates, U.S. Census Bureau.

Narrative:
The rate of non-fatal injuries among children aged 14 years and younger increased slightly in 2009.

Home visiting is an effective invention in preventing unintentional and intentional injuries to young children. During the visit health professionals review safety practices with parents or care-takers of the child. Illinois administers several home visiting programs the newest of which is Strong Foundations. IDHS, DCFS and ISBE are worked together during FFY'09 and FFY'10 to develop the state's infrastructure to support evidence-based home visiting programs. These three agencies provide program grants to support three different approaches to home visiting for the purpose of supporting families and reducing the risk of child maltreatment. The approaches are: Healthy Families Illinois, Parents as Teachers and the Nurse-Family Partnership. The three agencies are working with the Home Visiting Task Force, a broad-based advisory group of service providers, advocates and parents established by the Early Learning Council. The project, called "Strong Foundations," is supported by a cooperative agreement from the federal Children's Bureau for "Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment." The project concluded in FFY'10 due to the premature loss of federal funding.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	19.5	17.4	14.9	18.7	17.5
Numerator	526	472	393	493	461
Denominator	2700253	2720397	2643433	2632062	2636730
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2009 Illinois population estimates, US Census Bureau.

Notes - 2008

IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2008 Illinois population estimates, US Census Bureau.

Update: due to additional data provided by IDPH, 2008 figures revised 7/1/2010.

Notes - 2007
IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2007 Illinois population estimates, US Census Bureau.

Narrative:
The rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger that required hospitalization decreased between 2008 and 2009. Illinois continues to promote safety for young children via its Child Safety Seat program as well as other initiatives such as the "Click It or Ticket" campaign.

Please refer to the narratives for Health Status Indicators 3A and 3B as well for additional discussion.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	86.0	86.0	74.0	82.0	82.6
Numerator	1573	1605	1367	1525	1519
Denominator	1829459	1866573	1847996	1858677	1839391
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The number of non fatal injuries is hospital discharge data that were made final and available in 2010. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2009 Illinois population estimates, US Census Bureau.

Notes - 2008
The number of non fatal injuries is hospital discharge data that were made final and available in 2009. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2008 Illinois population estimates, US Census Bureau.

Notes - 2007
The number of non fatal injuries is hospital discharge data that were made final and available in 2008. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2007 Illinois population estimates, US Census Bureau.

Narrative:
Per IDOT's "Crash Facts and Statistics" 2009 report, "Drivers aged 16-24 account for the most drivers killed" than any other age range. However, per the IDOT report "Illinois Crash Data 2004-2008", even though the number of young drivers ages 16 to 20 increased by 1.0% from 2004 to 2008, the number of injury crashes declined by 23.3% over the same time period. Illinois has a number of programs that target young drivers such as "Operation Teen Safe Driving" and "PROM" (Please Return On Monday). These programs began in recent years and continue to promote safety awareness among young adults in motor vehicles.

Please refer to the narrative for Health Status Indicator 3C for additional discussion.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	32.8	33.2	34.8	36.7	37.6
Numerator	14273	14889	15736	16769	16854
Denominator	435581	448529	452277	457329	448663
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: IDPH, STD Section, and 2009 Census Estimates.

Notes - 2008
Source: IDPH, STD Section, and 2008 Census Estimates.

Notes - 2007
Source: IDPH, STD Section, and 2007 Census Estimates.

Narrative:
The Family Planning (FP) Program and the IDPH STD program are continuing to encourage and monitor the age-based screening criteria for Chlamydia. A mailing was sent by IDPH-STD to each Title X FP Clinic to provide screening recommendations and site-specific data on screening coverage rates by age group. The Family Planning delegate agencies continue to receive a list of the percent of clients less than 26 years of age who received Chlamydia and Gonorrhea testing and timeliness of treatment data.

Chicago. CDPH policy mandates all pregnant women should be screened at least once during their pregnancy. CDPH's STD/HIV/AIDS Division's Adolescent Program and HIV Counseling and Testing unit are meeting with key CPS staff to revise the Chicago Public School's (CPS) confidentiality and Sexually Transmitted Infection (STI) policies and procedures. The revised policy allows STI counseling and testing to occur in all high schools whether or not there is a school-based health clinic. The adolescent program also re-established collaborations with the Illinois Youth Center-Chicago (providing a STD/HIV Health Education curriculum to approximately 130 youth housed in the facility) and with the YMCA.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.9	10.3	10.5	11.5	12.2
Numerator	22551	23561	23405	25394	26743
Denominator	2276242	2279673	2232895	2203396	2197857
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: IDPH, STD Section, and 2009 Census Estimates.

Notes - 2008
Souce: IDPH STD Section, December 2008. Denominator revised to reflect 2008 Census Estimates.

Notes - 2007
Source: IDPH STD Section, December 2007. Possible error on the webpage claiming that 2007 data are provisional when the 2008 data are final.

Narrative:
The rate of women aged 20 through 44 years with a reported case chlamydia is steadily increasing. The statistics also reflect greater availability of screening services. The Family Planning program and the IDPH STD program undertake the following activities to reduce the rate of Chlamydia infection: testing all clients seeking pregnancy testing; retesting persons with positive tests three months after treatment to detect reinfection; and provide testing of partners of family planning clients with positive test results.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	181133	135166	30175	1051	8868	235	5638	0
Children 1 through 4	712819	534212	119093	2683	34858	518	21455	0
Children 5 through 9	882375	666865	147433	3162	39968	571	24376	0
Children 10	860403	647474	154435	3672	34003	779	20040	0

through 14								
Children 15 through 19	922089	690743	175269	3691	35287	832	16267	0
Children 20 through 24	917302	704576	153580	3820	40435	847	14044	0
Children 0 through 24	4476121	3379036	779985	18079	193419	3782	101820	0

Notes - 2011

Narrative:
Refer to Form 21 for the enumeration of infants and children aged 0 through 24 years of age. The distribution of infants and children by racial grouping suggests that Illinois is a diverse state comprised of several racial groupings and ethnicities. Exploring the trends and changes of the Census Estimated Population counts by race from one year to the next is at best a dubious analysis. However, that being said, a simple review of the 2008 versus the current 2009 estimates show that the "Black or African American" and "White" estimates stayed virtually the same. There were increases in the "American Indian or Native Alaskan", "Native Hawaiian or Other Pacific Islander", "More than one race reported" and "Asian" categories with the latter, the Asian race, being the most significant due to the larger absolute number of persons. The estimate of Asian infants and children grew by 2.4% from 2008 to 2009. Between age ranges there was little significant change except for large percentage increases in the "0 to 1" and "1 to 4" age ranges for the "American Indian or Native Alaskan" and "Native Hawaiian or Other Pacific Islander" categories which saw an average increase of around 20% each.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	134645	46488	0
Children 1 through 4	533496	179323	0
Children 5 through 9	674751	207624	0
Children 10 through 14	686350	174053	0
Children 15 through 19	759435	162654	0
Children 20 through 24	761101	156201	0
Children 0 through 24	3549778	926343	0

Notes - 2011

Narrative:
The distribution of infants and children by ethnic grouping suggests that Illinois is a diverse state. Exploring the trends and changes of the Census Estimated Population counts by ethnicity from one year to the next is at best a dubious analysis. However, that being said, a simple review of the 2008 versus the current 2009 estimates show that the "Total Not Hispanic or Latino" estimate stayed virtually the same. The "Total Hispanic or Latino" category saw an increase of over 2% with the largest percentage upward change appearing in the "5 through 9" and "15 through 19" age ranges with increases of about 4% and 3% respectively.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	256	124	131	0	1	0	0	0
Women 15 through 17	5653	3296	2294	11	24	2	0	26
Women 18 through 19	11744	7468	4143	28	71	3	0	31
Women 20 through 34	131741	102049	21620	205	7454	28	0	385
Women 35 or older	27240	21865	2913	37	2252	5	0	168
Women of all ages	176634	134802	31101	281	9802	38	0	610

Notes - 2011
The Unknown ages were put into 35 Plus Other/Unknown Race

Narrative:
Overall births declined from 2007 to 2008 by a total of 3,896 or about 2.2%. The decline was seen in the two largest racial categories, with "White" births declining by 2.5% and "Black or African American" births declining by 2.5%. However, there was an increase in the third largest racial category, "Asian". For Asian births there was an increase of 198 births in 2008 over 2007 for a 2.1% upward change.

For other discussion refer to Form 21 for the distribution of live births by maternal characteristics.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	175	81	0
Women 15 through 17	3693	1960	0
Women 18 through 19	8266	3478	0
Women 20 through 34	99682	32059	0
Women 35 or older	22074	5166	0
Women of all ages	133890	42744	0

Notes - 2011
Unknown Age total was placed under Ethnicity Not Reported / Women 35 or older

Narrative:
Overall births declined from 2007 to 2008 by a total of 3,896 or about 2.2%. The decline was seen in the "Not Hispanic or Latino" births which declined by 1.9% and also in the "Hispanic or Latino" births, which declined more, by 3.0%.

Please refer to the narrative for Health Status Indicator 7A for further discussion.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	1196	713	429	2	0	38	0	14
Children 1 through 4	186	114	62	1	0	8	0	1
Children 5 through 9	104	73	30	0	0	1	0	0
Children 10 through 14	162	107	51	0	0	4	0	0
Children 15 through 19	557	378	169	2	0	7	0	1
Children 20 through 24	791	534	235	1	0	19	0	2
Children 0 through 24	2996	1919	976	6	0	77	0	18

Notes - 2011

Narrative:
Most childhood deaths occur to infants (nearly 44 percent in 2007), followed by deaths among 20 -- 24 year olds (about 25 percent in 2007) and deaths among 15-19 year olds (about 18 percent in 2007).

When compared with the data submitted for the FFY'06 application (for calendar year 2002), there were 5.5 percent fewer deaths among children in 2007. There was a slight increase (nearly three percent) in the number of infant deaths (although there was a large increase in the number of live births, thus lowering the infant mortality rate). The number of deaths among children ages 1 through 4 and 5 through 9 years of age decreased by about 15 percent, and the number of deaths among children between 10 and 14 years of age decreased by nearly 30 percent. The proportion of deceased children who were Hispanic increased slightly from 2002 (17.2 percent) to 2007 (18.1 percent).

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY	**Total NOT Hispanic or**	**Total Hispanic or**	**Ethnicity Not**

Total deaths	**Latino**	**Latino**	**Reported**
Infants 0 to 1	929	239	28
Children 1 through 4	150	33	3
Children 5 through 9	83	21	0
Children 10 through 14	130	29	3
Children 15 through 19	474	79	4
Children 20 through 24	660	125	6
Children 0 through 24	2426	526	44

Notes - 2011

Narrative:
Please refer to the narrative for Health Status Indicator 8A.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	3558819	2674460	626405	14259	152984	2935	87776	0	2009
Percent in household headed by single parent	17.1	12.9	37.6	24.7	10.2	22.8	26.7	28.9	2009
Percent in TANF (Grant) families	2.7	0.7	11.3	0.4	0.8	5.6	0.2	0.0	2009
Number enrolled in Medicaid	1418894	537874	459090	969	27486	2305	3348	387822	2009
Number enrolled in SCHIP	73215	32157	6405	232	2292	117	343	31669	2009
Number living in foster home care	15490	6517	8594	17	38	0	0	324	2009
Number enrolled in food stamp program	951020	342317	390128	702	11074	1645	1793	203361	2009
Number enrolled in WIC	417005	223494	106590	447	8528	0	0	77946	2009
Rate (per 100,000) of juvenile crime arrests	1605.9	870.5	5370.8	218.3	188.4	0.0	0.0	248.0	2009
Percentage	3.5	1.9	7.6	3.6	1.1	1.1	2.4	0.0	2009

of high school drop-outs (grade 9 through 12)									

Notes - 2011
Source: 2009 Population Estimates, U.S. Census Bureau.

Census Source: B11001. HOUSEHOLD TYPE (INCLUDING LIVING ALONE) - Universe: HOUSEHOLDS
Data Set: 2008 American Community Survey -- 1-Year Estimates
Survey: 2008 American Community Survey

TANF Source: ILLINOIS DEPARTMENT OF HUMAN SERVICES
Bureau of Research and Analysis, Race/Ethnicity Counts of Persons Aged 0-19 for SFY 2009.

Source: IDHFS Eligibility and Demographic Data from the Medical Data Warehouse, Children ages 0 through 19 eligible on 7/1/2009.

Source: IDHFS Eligibility and Demographic Data from the Medical Data Warehouse, Children ages 0 through 19 eligible on 7/1/2009.

Source: ILLINOIS DEPARTMENT OF HUMAN SERVICES
Bureau of Research and Analysis, Race/Ethnicity Counts of Persons Aged 0-19 for SFY 2009.

Source: IDHS, Performance Support - Cornerstone.

Source: Illinois Criminal Justice Information Authority, and Census population estimates for 0 to 16 year olds.

Source: ISBE End of Year reports, Dropouts versus Total Enrolled in grades 9 through 12 for 2009 - 2009 school year.

Source: Foster home data provided by DCFS - letter dated 7/9/10. "Hispanic" is listed as Race so "Hispanic" count was added to "White" count to make total same as DCFS total.

Narrative:
Infants and children aged 0 to 19 years of age in miscellaneous situations or enrolled in various state programs are presented.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	2788677	770142	0	2009
Percent in household headed by single parent	12.0	26.2	0.0	2009
Percent in TANF (Grant) families	3.1	1.5	2.7	2009
Number enrolled in Medicaid	804651	403535	210708	2009

Number enrolled in SCHIP	28772	27857	15571	2009
Number living in foster home care	14606	884	0	2009
Number enrolled in food stamp program	645360	232720	72940	2009
Number enrolled in WIC	249135	167824	52	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	1605.9	2009
Percentage of high school drop-outs (grade 9 through 12)	3.3	4.7	0.0	2009

Notes - 2011

Narrative:
Infants and children 0 to 19 years of age in miscellaneous situations or enrolled in various state programs are arrayed here by Hispanic ethnicity.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	3144512
Living in urban areas	3545491
Living in rural areas	13328
Living in frontier areas	0
Total - all children 0 through 19	3558819

Notes - 2011
Source: US Department of Agriculture, 2003 Rural-Urban Continuum Codes; source: U.S. Census Bureau, 2009 Illinois Population Estimates (cc-est2009-alldata-17.csv).

The codes include 'urban' as part of the metropolitan counties. For the purposes of entry to this form they are combined.

Narrative:
Most of Illinois' children live in urban areas, which includes Rural-Urban Continuum codes 4 through 7 as defined by the USDA's Economic Research Service.

According to its website, the Economic Research Service classifies "metropolitan … counties by the population size of their [metropolitan] area, and nonmetropolitan … counties by degree of urbanization and adjacency to a [metropolitan] area or areas. The [metropolitan] and [nonmetropolitan] categories have been subdivided into three [metropolitan] and six [nonmetropolitan] groupings, resulting in a nine-part county codification. …

"…[Metropolitan] counties are distinguished by population size of the Metropolitan Statistical Area of which they are part. [Nonmetropolitan] counties are classified according to the aggregate size of their urban population. Within the three urban size categories, [nonmetropolitan] counties are further identified by whether or not they have some functional adjacency to a [metropolitan] area or areas. A [nonmetropolitan] county is defined as adjacent if it physically adjoins one or more [metropolitan] areas, and has at least 2 percent of its employed labor force commuting to central [metropolitan] counties. [Nonmetropolitan] counties that do not meet these criteria are [classified] as nonadjacent." 2

Compared with the data submitted with the FFY'06 application, the number of children living in rural areas (USDA ERS Rural-Urban Continuum Codes 8 and 9) decreased by 11.6 percent.

2 http://www.ers.usda.gov/briefing/rurality/ruralurbcon/, March 26, 2010

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	12901563.0
Percent Below: 50% of poverty	5.3
100% of poverty	11.9
200% of poverty	29.2

Notes - 2011
Source 1: The 2008 American Community Survey (C17024). The total for all ages is 12,568,150. The ACS is the only survey that supplies ratio levels of poverty with a population estimate close to the methods to fulfill requirements of TVIS Form 21, Indicator 11. Utilizing the total estimate above, poverty estimates for poverty below 50% is 5.4; at 100% is 12.2%; at 200% is 30%. These estimates are close to poverty by population estimates shown as final on Form 21, Indicator 11.

Source 2: The 2008 Current Population Survey (POV46). The total for all ages is 12,687,000. The CPS supplies the percent of poverty at 100%. Utilizing the total estimate above, poverty estimates for poverty below 50% cannot be calculated; at 100% is 12.3%; at 200% is 29%. These estimates are close to poverty by population estimates shown as final on Form 21, Indicator 11.

Source 3: The 2008 Population Estimate for Total are specific age breakouts 18-64 and 65+. Children have their own estimates and are not included in the total. See Indicator 12.

The ACS and the CPS counts are individuals and not families for age-specific analysis.

For the purposes of this form in creating levels of poverty for the select MCH population, the official 2008 Population Estimate from the Census Bureau are incorporated along with the C17024 ACS ratios of poverty below 50, 100, and at 200.

The ACS calculation for the 3 breakouts require the addition of the population numbers at the ratio levels of under 0.50, plus 0.50 to 0.99, plus 1.00 to 1.24, plus 1.25 to 1.99. The percent calculations have been extrapolated to the 2008 population estimate for the total population (18-64 and 65+).

Narrative:
Nearly 30 percent of Illinois' population is at or below 200 percent of poverty.

When compared with the data submitted with the FFY'06 application, the total population of the state has increased by 2 percent (from 12.7 to 12.9 million persons). The proportion of the population that is very poor (incomes below 50 percent of the federal poverty standard) remained the same or 5.3 percent. The proportion of the population that is impoverished (incomes at or below the federal poverty standard) decreased from 12.6 to 11.9 percent.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	3762998.0
Percent Below: 50% of poverty	6.2
100% of poverty	14.2
200% of poverty	36.6

Notes - 2011

Source 1: The 2008 American Community Survey (C17024). The total of individuals whom poverty is determined are for ages 0-17 (not children 0-19). The ACS is the only survey that supplies ratio levels of poverty with a population estimate close to the methods to fulfill requirements of TVIS Form 21, Indicator 12. Utilizing the total estimate above, poverty estimates for poverty below 50% is 7.5; at 100% is 17.0%; at 200% is 43.9%. These estimates are close to poverty by children aged 0-19 shown as final on Form 21, Indicator 12.

Source 2: The 2008 Current Population Survey (POV46). The total for children aged 0-17 is estimated at 3,180,000. The CPS supplies the percent of poverty at 100%. Utilizing the total estimate above, poverty estimates for poverty below 50% cannot be calculated; at 100% is 19.3%; at 200% is 38.6%. These estimates are close to poverty by population estimates shown as final on Form 21, Indicator 12.

Source 3: The 2008 Population Estimate for Total are specific age breakouts for children 0-19. Children have their own estimates and are not included in the total. See Indicator 12.

The ACS and the CPS counts are individuals and not families for age-specific analysis.

For the purposes of this form in creating levels of poverty for the select MCH population, the official 2008 Population Estimate from the Census Bureau are incorporated along with the C17024 ACS ratios of poverty below 50, 100, and at 200.

The ACS calculation for the 3 breakouts require the addition of the population numbers at the ratio levels of under 0.50, plus 0.50 to 0.99, plus 1.00 to 1.24, plus 1.25 to 1.99. The percent calculations have been extrapolated to the 2008 population estimate for children aged 0-19.

Narrative:

More than a third (36.6%) of Illinois' children 0 to 19 years of age are living at or below 200 percent of poverty.

Compared with the data submitted with the FFY'06 application, the proportion of children who live in very poor families (with incomes below 50 percent of the federal poverty standard) decreased from 7.7 to 6.2 percent of the population of children; the proportion of children who live in impoverished families (with incomes at or below the federal poverty standard) decreased from 17.4 to 14.2 percent of the population.

F. Other Program Activities

Women of Child-Bearing Age - A statewide Pre/Interconceptional Care Committee was formed in FY'07, with the goal of developing and implementing a three- to five-year strategic plan. Membership consists of representatives from IDHS, IDHFS, IDPH, local Health Departments, Delegate Family Planning programs, March of Dimes, Illinois Maternal and Child Health Coalition and others. To date, a grid outlining recommended components of pre/interconceptional care has been developed, an Education and Outreach sub-committee has been formed, and a social marketing strategy is being defined.

With grant funds from the American College of Obstetricians and Gynecologists, CityMatCH and the NHSA, IDHS and IDPH are collaborating on a project to further reduce perinatal transmission of HIV. The objective of the FIMR/HIV Prevention Methodology is to review, identify, address, and reduce missed opportunities for prevention of mother-to-child HIV transmission. To this end, it is important to design protocols that will identify cases from a broad array of settings within a community and prioritize the review of cases that are more likely to elicit opportunities for improvement of systems.

Fetal Alcohol Syndrome - The Department was awarded a $1 million contract from Northrop Grumman to implement a Fetal Alcohol Spectrum Disorder Prevention Program statewide over the next five years. The Brief Intervention for Alcohol Use will become part of the Department's existing WIC and Family Case Management services to pregnant women. A demonstration of the project is being conducted in Rockford, Illinois, through the Winnebago County Health Department and the Macon County Health Department in Decatur, Illinois. Over 3,600 pregnant women have been asked about their alcohol use prior to pregnancy since the project began in 2008 and over 200 women have received a Brief Intervention. Plans are underway to expand to three additional sites in 2010 and 2011. Staff requires intensive training and follow-up. Statewide expansion will occur in 2012.

Early Childhood Development - The Early Learning Council, created in 2003 by Public Act 93-0380, coordinates existing programs and services for children from birth to five years of age in order to meet the early learning needs of children and their families. The Council is comprised of gubernatorial and legislative appointees representing a broad range of constituencies, and the MCH program is represented on four of five committees.

The Council chose to develop a comprehensive plan for Preschool for All based on voluntary access, past planning efforts, and ensuring that all Illinois children are safe, healthy, eager to learn, and ready to succeed by the time they enter school.

Children's Mental Health - The Illinois Children's Mental Health Partnership envisions a comprehensive, coordinated children's mental health system comprised of prevention, early intervention, and treatment services for children ages 0-18 years and for youth ages 19-21 who are transitioning out of key public programs. The MCH program is represented on the Early Childhood Committee of the Partnership and its work groups. The work of the Committee focuses on:

(1) An early childhood mental health consultation initiative,
(2) The adoption of diagnostic codes for very young children,
(3) Increasing the response to maternal perinatal depression,
(4) Establishing social emotional and developmental screening and assessment,
(5) Expanding and developing the early childhood mental health workforce, and
(6) Ensuring that parents are equal partners in the emerging children's mental health system.

G. Technical Assistance

See Form 15 for this information.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	22100000	21694052	22100000		21700000	
2. Unobligated Balance *(Line2, Form 2)*	1268100	0	1268100		0	
3. State Funds *(Line3, Form 2)*	28829419	37310134	23533415		28696702	
4. Local MCH Funds *(Line4, Form 2)*	0	930324	0		0	
5. Other Funds *(Line5, Form 2)*	234421607	273784151	225029502		251784525	
6. Program Income *(Line6, Form 2)*	8830334	7824116	9183547		8000000	
7. Subtotal	295449460	341542777	281114564		310181227	
8. Other Federal Funds *(Line10, Form 2)*	324118700	357901907	324156200		414286114	
9. Total *(Line11, Form 2)*	619568160	699444684	605270764		724467341	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	25565202	23154955	24286942		22192394	
b. Infants < 1 year old	44847585	43125162	42605206		42360122	

c. Children 1 to 22 years old	162668454	219023314	153674240		195603720	
d. Children with Special Healthcare Needs	18395616	17833353	17658400		17107000	
e. Others	43144919	38405993	42028985		32065271	
f. Administration	827684	0	860791		852720	
g. SUBTOTAL	295449460	341542777	281114564		310181227	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		0	
c. CISS	140000		140000		105000	
d. Abstinence Education	1834600		1834600		0	
e. Healthy Start	1775000		1775000		1484650	
f. EMSC	0		0		0	
g. WIC	253500000		253500000		352933300	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	21586800		21586800		19579600	
k. Other						
Child Care	0		0		1066000	
Family Violence	0		0		2574500	
Other Demonstrations	0		0		790150	
Substance Abuse	0		0		16466293	
Title X	7585200		7585200		6742978	
Title XX	14322900		14322900		10908090	
UNHS	112500		150000		225000	
Youth Services	2833000		2833000		1410553	
Closing the Gap	562500		562500		0	
Family Violence Prev	2842100		2842100		0	
Substance Abuse Var	16924100		16924100		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	71231435	115955386	67730110		121028058	
II. Enabling Services	191935387	165829639	181612564		142071786	
III. Population-Based Services	11154445	40824290	11643864		31913717	
IV.	21128193	18933462	20128026		15167666	

Infrastructure Building Services						
V. Federal-State Title V Block Grant Partnership Total	295449460	341542777	281114564		310181227	

A. Expenditures

INTRODUCTION. In general, expenditures for individual programs were somewhat below budgeted amounts. This is due in part to a gubernatorial instruction to reserve state funds in response to budgetary shortfalls and in part to the differences that result from budgeting on a state fiscal year and reporting expenditures on a federal fiscal year. Large differences between budgeted and expended amounts are due to inclusion of additional expenditures and reclassification of expenditures. The effect of reclassification is especially apparent on Form 5.

FORM 3. IDHS reported an additional $79 million in expenditures for FFY'09. The final amount received for the MCH Block Grant, $21.7 million, was somewhat less than the amount used in the FFY'09 budget projection ($22.1 million). The State of Illinois has expended the entire FFY'09 award. IDHS, IDPH and DSCC provided a total of $37.3 million in state funds to meet Title V's match and Maintenance of Effort requirements. This amount exceeds both required amounts. The State of Illinois reports the amount of local funds used to match expenditures of Title V Section 510 (Abstinence Education) funds as "local funds" for the MCH Block Grant. The additional expenditures of Other State Funds ($39 million more than the amount budgeted) reflect the inclusion of all non-federal Part C Early Intervention program funds in the expenditure report. Prior reports have included only the case management funds. The State of Illinois reports the amount of funds collected by Title X (Family Planning) delegate agencies as program income. Collections were below expectations. The Department received and expended approximately $40 million more for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) in FFY'09 than originally projected, while expenditures of other federal funds were below the budgeted amount, resulting in a net increase in expenditures of $34 million.

DSCC expended $18.0 million for CSHCN from all sources in FFY'09, an aggregate decrease of $2.1 million from FFY'08. The decrease in overall spending for CSHCN was primarily from Other Fund sources which accounted for $1.8 million of the decrease, while the State sources were reduced by $0.3 million. While the primary reduction in spending was from Other Resources, the federal MCH Block Grant fund allocation remained the same in FFY'09 at $6.6 million. The Other Federal Funds used for CSHCN purposes increased slightly to $0.2 in FFY'09.

FORM 4: Expenditures Pregnant Women were $2.4 million less than the amount budgeted largely as the result of using a different combination of state and federal funds to pay for the Cornerstone management information system than originally budgeted and changes in the way that federal-state partnership funds used to pay for the Cornerstone system are allocated on Form 4. The additional expenditures for children reflect the allocation of nearly all non-federal Early Intervention funds (approximately 90 percent of the total), the addition of state funds for substance abuse prevention and additional funds for operations. Expenditures for Others were approximately $4.7 million less than the amount budgeted. While IDHS allocated more of its training and family planning expenditures to this category, the increases were offset by the reclassification of substance abuse program and operations expenditures and a $3.3 million reduction in expenditures for domestic violence services.

The IDHS is required by Circular A-87 to have a Public Assistance Cost Allocation Plan (PACAP). The U.S. DHHS Division of Cost Allocation has requested that IDHS have a Departmental Indirect Cost Allocation Plan for indirect costs to identify dollars that then become a part of the PACAP each quarter in claiming federal reimbursement. IDHS does not use indirect rates for its

programs. It is considered full costing on a quarterly basis. Amounts budgeted for indirect costs are converted to direct costs through the PACAP. The costs identified as administration reflect audit costs and PACAP costs in excess of actual personal services expenditures.

In FFY'09 DSCC spent 10.4 percent or $2.1 million less on CSHCN services than in FFY'08. The federal MCH Block Grant funds spent to support the CSHCN remained at $6.6 million, while the amount spent from State and Other Resources was reduced by $2.1 million from FFY'08 to FFY'09.

FORM 5: The additional expenditures for Direct Health Care services reflect the inclusion of all non-federal expenditures for the Part C Early Intervention program and the inclusion of (Family Planning) program income. The amount expended for Enabling services was below the budgeted amount due to a number of changes in the classification of expenses. Expenditures for the Department's information systems (principally Cornerstone), training and program evaluations, Healthy Child Care Illinois and Coordinated School Health were reclassified as expenditures for Infrastructure Building. The Community Youth Services program was reclassified from Enabling to Population Based. Offsetting these reductions, the full amount of Part C expenditures for the Child and Family Connections agencies were reclassified as expenditures for Enabling services. The significant increase in expenditures for Population-Based services resulted from the reclassification of expenditures for the Teen REACH program, the Comprehensive Addiction Prevention program, Community Youth Services and Communities For Youth programs as Population-Based. Finally, the difference between the amount budgeted and expended for Infrastructure Building reflects the inclusion of expenditures for the Cornerstone management information system and Healthy Child Care Illinois, a change in the allocation of expenditures for the Part C program and the allocation of IDHS' expenditures for operation among all four types of services.

In FFY'09 DSCC spent $6.8 million on enabling services and $6.0 million on infrastructure building services, a decrease of $0.6 million and $0.8 million respectively from FFY'08. The decrease in spending was largely due to more stringent hiring practices in replacement of care coordination staff and imposed reductions in the CSHCN operational budget allocations of State and Other Resources. The amount spent on direct services was reduced from $5.8 million in FFY'08 to $5.1 million in FFY'09. This reduction in spending was in large part due to policy changes requiring CSHCN families with no private health insurance to apply to the State Medicaid Program to be the primary payer for health care.

B. Budget

STATE BUDGET HIGHLIGHTS - The State of Illinois is facing unprecedented fiscal problems. The shortfall in state General Revenue Funds (GRF) for the current year is expected to be $13 billion. The Comptroller already estimates that $6 billion in SFY'11 obligations will have to be deferred until SFY'12.

The IDHS' GRF budget has been reduced by $312.6 million, or 7.7 percent, for SFY'11, with overall operations reduced by $49.8 million and grants reduced by $262.8 million. The grant reductions reduce or eliminate non-Medicaid programs in mental health and developmental disabilities, extend payment cycles for developmental disability programs and limit eligibility for mental health, developmental disability and rehabilitation services. Additional GRF amounts may be placed in reserve during the course of the fiscal year.

The GRF allocated to the Division of Community Health and Prevention has been reduced by $18.1 million or 8.2 percent for SFY'11. With three exceptions, this represents a ten percent reduction in all DCHP GRF accounts. The budget for FCM was reduced by 4.5 percent in order to preserve Medicaid matching funds. The budgets for HFI and PTS were not reduced from SFY'10 levels in order to meet the Maintenance of Effort requirement for the Patient Choice and

Affordable Care Act's Maternal, Infant and Early Childhood Home Visiting Program. Overall, these reductions are expected to decrease the number of persons served through MCH programs by 42,100. The largest anticipated decrease is 15,300 women, infants and young children in FCM.

The IDPH's GRF budget has been reduced by $17 million, or 11 percent, for SFY'11. These reductions will affect Women's Health Promotion, Rural Health, Community Health Center Expansion, Medical Student Scholarship, Prostate Cancer Awareness, Family Practice Residency and Immunization Outreach grants.

The IDHFS' GRF budget has been increased by $162 million, or two percent, for SFY'11. This is the result of a $169.2 million increase in Medicaid appropriations in order to maintain a 30 day payment cycle and a $7.2 million decrease in agency operations.

In recent years DSCC has experienced a significant reduction in State, Federal and Other Resources available for CSHCN. Through effective strategies, including staff training on public and private benefit plans and expanded resources to help families understand how to effectively use their health insurance, DSCC has been able to counteract funding deficiencies. The amount of funds available to pay for direct services to children and families continues to decline. In FFY'09, DSCC spent $5.1 million on direct services for CSHCN, $0.7 million less than was spent in FFY'08. By implementing these new strategies, DSCC has been able to redirect funds to assist families with more enabling services such as transportation assistance, health education and family support services. DSCC has implemented an incentive program for families to maximize their health benefits by reimbursing families their co-payments and out of pocket costs on medical visits and medications. In FFY'09 DSCC spent $6.8 million on enabling services earmarked to help families obtain and maximize health benefits and to provide care coordination services. In addition, DSCC spent $6.0 million on infrastructure building services to continuously assess the needs of CSHCN families and find ways to improve the systems of care through program assessments, policy evaluation and quality assurance reviews.

FFY'11 BUDGET: IDHS, DSCC and IDPH use state General Revenue Funds, Tobacco Settlement funds, Title IV (DCFS) funds, Title X (Family Planning) funds, Title XX (Social Services Block Grant) funds, MCH Set-aside funds, Healthy Start Initiative funds, funds from the Substance Abuse and Mental Health Services Administration, USDA funds for Special Supplemental Nutrition Program for Women, Infants and Children (WIC), U.S. Department of Education funds for Part C of the Individuals with Disabilities Education Act and Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP), U.S. Department of Justice funds for juvenile justice and domestic violence and funds from private foundations in addition to Title V Block Grant funds to achieve the objectives described in this application.

FORM 3. The State MCH Budget is anticipated to be $727 million FFY'11. This is an increase of $122 million from the budget presented in the FFY'10 application but is an increase of $27.6 million from the FFY'09 expenditures included in this year's Annual Report. This increase is the result of two factors: including the entire budget for non-federal funds used in the Part C Early Intervention program and a large anticipated increase in WIC funds for food expenditures. IDHS has traditionally reported the local funds used to match Abstinence-Only Education funds granted to Illinois through Section 510 of Title V as "Local MCH Funds." As the former federal appropriation for Abstinence-Only Education funds has expired and no additional guidance regarding the new federal appropriation has been issued by MCHB at the time of this application, no "Local MCH Funds" have been included in the State MCH Budget for FFY'11. The amount of State MCH Funds (Line 3) is sufficient to meet Illinois' match and Maintenance of Effort requirements (see below). The amount of State MCH Funds and Other Funds (Line 5) budgeted for FFY'11 are lower than FFY'09 expenditures, reflecting the financial challenges facing the State of Illinois.

FORM 4. The Federal-State Block Grant Partnership for FFY'11 includes $21.7 million in services

for pregnant women, $42.4 million in services for infants, $198.2 million in services for children and adolescents, $17.1 million in services for children with special health care needs and $32 million in services for others. The amounts budgeted for pregnant women and infants are less than the amounts budgeted for FFY'10 and less than the amount expended for FFY'09. This reflects a decrease in the budget for Family Case Management and Targeted Intensive Prenatal Case Management for SFY'11. The amount for children and adolescents is greater than the amount budgeted for FFY'10 but less than the amount expended for FFY'09. The change from FFY'10 reflects the inclusion of additional DCHP funds in budget report. The change from FFY'09 reflects reductions in GRF. The budget for CSHCN is approximately $500,000 less than FFY'10 budget and $700,000 less than FFY'09 expenditures. The trend in resources for CSHCN was discussed above.

FORM 5. The Federal-State Block Grant Partnership for FFY'11 includes $121 million in Direct Health Care services, $142 million in Enabling services, $31.9 million in Population-Based services and $15.2 million in Infrastructure Building. These are significant changes from the FFY'10 budget and less than, but comparable to, FFY'09 expenditures. Most of the changes reflect reclassification of program budgets among the four types of services described on Form 5 and an increase in the amount of non-federal Part C Early Intervention funds included in the budget report.

The additional expenditures for Direct Health Care services reflect the inclusion of all non-federal expenditures for provider payments in the Part C Early Intervention program. Expenditures for DCHP's information systems (principally Cornerstone), training and program evaluations, Healthy Child Care Illinois and Coordinated School Health programs were reclassified from Enabling to Infrastructure Building. The Community Youth Services program was reclassified from Enabling to Population-Based. Offsetting these reductions, the full amount of Part C expenditures for the Child and Family Connections agencies were reclassified as expenditures for Enabling services. The significant increase in expenditures for Population-Based services resulted from the reclassification of expenditures for the Teen REACH program, the Comprehensive Addiction Prevention program, Community Youth Services and Communities For Youth programs as Population-Based.

MATCH AND MAINTENANCE OF EFFORT. The amount of state support for the MCH program was $27,569,600 in FFY'89. The required match for FFY'11 is $16,275,000, based on an anticipated award of $21.7 million. The State of Illinois has exceeded these requirements by providing $28.7 million in state funds.

PROGRAMS OF PROJECTS - IDPH had five "programs of projects" in 1981. Maternal and Infant (M&I) and Children and Youth (C&Y) projects were consolidated with the childhood lead project at the Chicago Department of Public Health and continue as a consolidated MCH project (the "MCH Mini Block Grant"). The Winnebago Family Planning Project and the Lake County Family Planning Demonstration Project have continued through SFY'10 as part of IDHS' comprehensive Family Planning program. The Intensive Infant Care Project at St. Francis Medical Center in Peoria continues to operate as a part of the Illinois regionalized perinatal care program. The amount of funding awarded to each project is as follows: St Francis Perinatal Center, $325;649; Chicago Department of Public Health (M&I, C&Y) $5,017,400 and the dental projects, $342,000. The Family Planning program is currently in the final stages of competitive rebidding; an announcement of SFY'11 awards is expected during the Summer of 2010.

SECTION 501 PURPOSES - Sections 501(a)(1)(A) through (D) of the Social Security Act as amended by OBRA'89 describe the basic purposes of the MCH Block Grant. Illinois plans to use MCH Block Grant funds to achieve these purposes through its system development activities, as well as by providing grants for preventive and primary care services to agencies statewide. The purposes outlined in Sections 501(a)(1)(A) and (B) are achieved by the grants IDHS awards for family case management and adolescent health promotion and the grants that IDPH awards for perinatal care. The purpose outlined in Section 501(a)(1)(C) is achieved by DSCC, in part with

MCH Block Grant funds. The purpose outlined in Section 501(a)(1)(D) is the principle responsibility of DSCC. The proportion of funds used for Sections 501(a)(1)(A) and (B) is 70 percent, and for Sections 501(a)(1)(C) and (D) is 30 percent.

ALLOCATION OF RESOURCES - IDHS receives the MCH Block Grant and administers primary care programs. IDHS transfers 30 percent of its block grant funds to DSCC for the CSHCN program. IDHS gives highest priority to those areas in Illinois that have high concentrations of low-income families (an area where 20 percent of the families, or at least 1,000 individuals, have an income at or below the federal poverty level), that are medically under-served areas, or are areas of high infant mortality and teenage pregnancy. Priority is also given to areas with high rates of poverty that have a demonstrated need for services. Program grants are awarded to local political jurisdictions or private, non-profit agencies. Applications are reviewed by a committee and recommendations for funding are made to the Secretary of the Illinois Department of Human Services. Continuation applications receive priority in order to maintain continuity of services.

SECTION 508 PURPOSES - IDHS has continued to direct funds to mandated Title V activities. Funds allocated to the State under this Title will only be used in a manner that is consistent with Section 508 to carry out the purpose of Title V or to continue activities previously conducted under the Consolidated Health Programs. IDPH continues to fund statewide projects addressing lead poisoning, and genetic diseases, while IDHS continues to fund programs related to adolescent pregnancy.

FEE SCALE - IDHS has not established a fee scale for use by its MCH program grantees and has no plans to do so. Each project funded through the MCH program may elect to charge eligible recipients for certain services provided by the project. However, a flexible sliding fee scale must be used when a project intends to charge for services and no fees are charged to low-income clients. The fee scale must be included for approval in the project application prior to any fees being charged. Further, all projects are required to have agreements with the Medicaid program for reimbursement of covered services for project patients who are Title XIX, Title XXI or All Kids recipients. Steps must also be taken to obtain reimbursement from non-profit, semi-private and private medical insurance programs when those programs cover services rendered by the projects. Finally, outpatient services must be provided at rates established by the Illinois Department of Healthcare and Family Services for the Medicaid program. These provisions are made to ensure that mothers and children from low-income families are not charged for services.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.